With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Annual Report and Accounts

## for the period 1 April 2010 to 31 March 2011

# SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

# ANNUAL REPORT AND ACCOUNTS FOR THE PERIOD 1 APRIL 2010 TO 31 MARCH 2011

Presented to Parliament pursuant to Schedule 7, paragraph 25(4) of the National Health Service Act 2006

## Statement from the Chair and Chief Executive

Welcome to the Trust's annual report for the year 1 April 2010 to 31 March 2011.

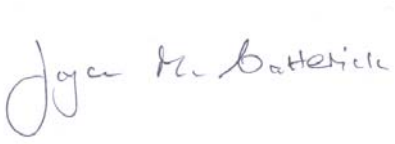
This report illustrates a further year of growth and success. The Trust has worked hard to make the most of the opportunities afforded by Foundation Trust status, achieved on 1 May 2009. We have a thriving membership, which reflects the communities we serve and are reaping the benefits of working with our Members' Council who bring valuable insight and influence to the way we work.

The financial freedoms open to foundation trusts have provided the opportunity to work in new ways, to look at specific projects and initiatives to ensure best value and to end the year in a healthy financial position.

Our staff, as always, have worked hard over the last year to deliver care of the highest quality. It is through their loyalty and commitment, and because of the high standards they set themselves, that our service users and carers receive the best possible care and support. In November 2010, we held our second celebration event for staff, 'Excellence 10'. This once again demonstrated the excellent work our staff do with over 100 services recognised for their good work. The 'Excellence' awards will continue to be an annual event to recognise and celebrate our staff achievements.

We have made improvements to the environment in which we offer care, for example, our in-patient services transferred from St. Luke's Hospital to improved facilities on our Dales Unit site in Halifax, and the Priestley Unit in Dewsbury. With the vast majority of our care provided in people's home and in community settings, it is important that we invest in services that meet identified local need. Service users and carers continue to help us work through the plans to make sure services are provided as close to our service users as possible and that any changes take place in the most effective and supportive way.

Thank you for taking the time to read this report; we hope you find it interesting and informative.



Joyce Catterick OBE
**Chair**

Steven Michael
**Chief Executive**

**3 June 2011**

# Directors' report

## Background

On 1 May 2009, our Trust was authorised as an NHS Foundation Trust and became South West Yorkshire Partnership NHS Foundation Trust. Previously we were known as South West Yorkshire Mental Health NHS Trust, established following the merger of a number of NHS bodies in April 2002.

We are the lead provider of specialist mental health services for people over 18 years and a key player in the provision of learning disability services. We also offer early intervention in psychosis services to young people aged 14 years and over. Services are provided to a population of approximately 900,000 across the South West Yorkshire districts of Calderdale, Kirklees and Wakefield. This population is very diverse with:

- a combination of urban and rural communities;
- high unemployment in some areas;
- pockets of deprivation and areas of relative wealth within all three districts;
- communities with a high proportion of people from Black and Minority Ethnic (BME) groups including first generation immigrants, refugees and asylum seekers.

The Trust is also one of two NHS providers of medium secure forensic services to a population of five million across the Yorkshire and Humber region.

As at 31 March 2011, the Trust employed just under 2,500 staff, who provide services from over 40 main sites. 98 per cent of the care we provide is in the local community, working with people in their own homes. During 2010/11 we had direct contact with approximately 27,500 people, about 8,000 of whom were using our services for the first time.

We have worked with our stakeholders to develop a structure for the organisation and a culture which:

- meets performance targets and modernises services;
- meets the expectations of service users, carers and staff in the context of a specialist organisation;
- delivers financial balance;
- has sound reporting systems;
- has good governance;
- supports workforce development;
- facilitates risk assessment and management;
- supports sound clinical policies and procedures;
- promotes mutual respect and wellbeing.

During 2010/11, we have worked with our commissioning partners on the Transforming Community Services agenda, which seeks to transform the commissioning of community services by establishing alternative arrangements for their delivery. Under TCS, every Primary Care Trust (PCT) in England will cease to be a direct provider of primary care services such as community nursing and health visiting. The Trust agreed the transfer of community and mental health services in Barnsley, substance misuse and specialist health improvement services from Calderdale, and child and adolescent mental health services and health and wellbeing services from Wakefield.

## Our Mission, Vision, Values and Goals

The Trust's mission was reviewed by Trust Board during 2010/11 to ensure it remained relevant and appropriate for the services the Trust provides in the future. As a result, the

mission was changed to “enabling people with health problems and learning disabilities to live life to the full”. Our vision is to be:

- the service of choice for users;
- the employer of choice for staff;
- the provider of choice for commissioners and partners.

Our Values

- Be open and honest and do what we say we will.
- Treat all people fairly with dignity and respect.
- Recognise rights and responsibilities.
- Help people stay in control.
- Value partnerships to reach our full potential.
- Be an organisation that learns and develops

Our goals are to:

- develop our services to meet local expectations and make the most of opportunities to progress and improve;
- ensure we have effective systems to support service development;
- maintain and develop the Trust’s culture so that it reflects our values and helps us provide services that are sensitive to the needs of a diverse population;
- develop a clear organisational structure which promotes accountability and responsibility at all levels;
- find opportunities to develop new services and ways of working which help us maintain our reputation as a lead provider;
- ensure partnerships are developed which help us achieve our vision and brings benefits for the communities we serve.

## Our Strategy

The five strategic objectives outlined in the Trust’s business plan provide the organisational focus to direct where we need to concentrate our efforts to remain a successful and sustainable organisation and meet the requirements of both the national and local agendas. These are to:

- consolidate and develop local pathways for services;
- increase sub-specialisation;
- strengthen our position as a regional medium secure and prison service provider;
- explore opportunities in relation to geographical expansion;
- become a leading edge thinker by developing a Quality Academy to drive the delivery of high quality care.

During the year, delivery of our strategy was measured and monitored through corporate objectives, cascaded throughout the Trust in the form of team and individual objectives.

- The consolidation of local pathways has continued with service and performance improvement in all localities, evidenced by improved reference costs and delivery of key performance indicators set by Trust Board. In addition, this has included incorporation of further community services in Calderdale and Wakefield. Sound partnership working has been at the heart of this, leading to a strong contractual position in all areas, supported by district based management through Business Delivery Units (BDUs), operating in shadow form before formal establishment in November 2010, and a robust change management programme.

- In relation to Specialist Services, the Attention Deficit Hyperactivity Disorder (ADHD) service has continued to flourish and a senior clinician has been appointed to identify areas for potential expansion.
- The Forensic Service has identified priorities for expansion and redevelopment. This has included the development and Trust Board approval of a business case for 10 further beds and significant refurbishment of existing facilities which has been welcomed by Specialist Commissioners. The Trust, as a result will have the largest market share for Forensic Services in the region. Relationships with commissioners remain positive and robust, based on delivery of key performance targets.
- The development of the Quality Academy approach (QA) has focused on harnessing the optimum Support Service offer. In support of this, the Trust has continued its relationship with the Jonkoping community in Sweden, appointed an Assistant Director to support QA development and embarked on a lean systems programme Trust-wide.
- In the first few months of 2011, the Trust has worked to acquire services from Barnsley, Calderdale and Wakefield under the Transforming Community Services (TCS) initiative. In particular, the acquisition of Barnsley community services and mental health services represents a significant transaction for the Trust increasing turnover by 71%. This transaction has been assessed by Monitor and rated 3 for financial risk and green for governance. The acquisition has been approved by Trust Board and the services transferred on 1 May 2011.

Overall performance is managed through key performance indicators reviewed regularly by the Trust Board, through the Assurance Framework and risk register, appraisal and performance development system, compliance against regulatory requirements, external agencies and visits, and through work to produce the Trust's Quality Accounts.

These performance measures support the delivery of the following strategic outcomes.

- To improve the health and well being of our service users and influence the well being of the communities we serve.
- To manage risk and deliver safe, high quality services.
- To improve the service user experience, engaging them in the design and delivery of services.
- To ensure that the Trust remains viable and sustainable, into the future.
- To improve the efficiency and productivity of our services in line with best evidenced based practice.

## External Strategic Risks

At the beginning of 2010/11, the Trust recognised that the main challenge to the NHS was the scale of the financial challenge as the consequences of the recession begin to bite within public sector organisation, particularly local authorities. This provided the principle risk to the organisation as the Trust moves forward and included:

- financial challenges relating to "flat cash" allocations from commissioners from 2011/12 onwards creating a significant cost pressure within the system;
- potential decommissioning of services as a consequence of PCT World Class Commissioning decisions and Quality, Innovation, Productivity and Prevention (QIPP) plans;
- the impact of developments within the acute sector that have a significant financial impact on commissioners, therefore placing the Trust block contract at risk;
- the potential impact of the implementation of contract currencies and possible tariffs for mental health services;

- the impact of Transforming Community Services (TCS) if the Trust is unable to benefit from its implementation;
- political and reputational risks related to the re-provision of St Luke's and the future use of Castleford and Normanton District Hospital;
- increased competition for NHS contracts.

To support the Trust in these challenging times, leadership and management capacity and competency to drive transformational change will be crucial. During 2010/11, the Trust made the transition from services organised on a care group basis to services organised in line with districts with the creation of four Business Delivery Units (BDUs) to cover Calderdale, Kirklees, Wakefield and Forensic services.

The development of BDUs has been a key element of the Leadership and Management Framework. BDUs support the next phase of organisational development for the Trust, with BDUs being the Trust's agreed approach to implementing service line management in accordance with Monitor guidance. The introduction of BDUs has brought the following benefits.

- Devolved decision making as close to service delivery as possible, including greater control of resources that impact on the quality of care at service level.
- Increased responsiveness to the needs of service users and carers.
- An equal partnership between clinicians and managers.
- Clear, quantifiable objectives, linked to the annual plan and integrated across clinical, financial, workforce and estates issues.

Effective clinical leadership at all levels working in partnership with general management is vital given the need to re-design service models. The Trust has developed a competency framework to support the new arrangements, which provides a framework for assessment, development and succession planning for key roles and will be fully implemented by May 2011.

There is more information on how the Trust mitigates against risk in the annual governance statement, which is incorporated into this report.

# The Way we Work

## Our Trust Board

The Trust Board is responsible for setting the strategic direction for the organisation in order to enable it to respond to the requirements of its stakeholders whilst remaining effective, sustainable and viable. The Board has the overall responsibility for probity (standards of public behaviour) within the Trust and is accountable for monitoring the organisation against the agreed direction and ensuring corrective action is taken where necessary.

The Scheme of Delegation describes those powers that are reserved to Trust Board and these are generally those matters for which the Trust remains accountable to the Secretary of State and to its regulator, Monitor, as well as describing the delegation of the detailed application of Trust policies and procedures to the appropriate level. Trust Board remains accountable for all its functions, even those delegated to the Chair, individual directors or officers and has in place arrangements to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

The composition of the Trust Board is in accordance with the Trust's Constitution, to fulfil its statutory duties and functions, and remain within Monitor's Terms of Authorisation. All Non-Executive Directors are considered to be independent.

The Trust Board works with the Members' Council, whose role is to ensure that the Board, which retains responsibility for the day to day running of the Trust, is accountable to the local communities the Trust serves. The Members' Council oversees the activities of the Trust and helps shape future strategy. It has a number of defined responsibilities laid down in the National Health Service Act 2006, which can be summarised into three roles around advice, guardianship and strategy. Membership of the Council is outlined below.

The Chair is responsible for ensuring that Trust Board focuses on the strategic development of the Trust and for ensuring robust governance and accountability arrangements are in place, as well as undertaking an evaluation of the performance of the Board, its committees and individual Non-Executive directors. The Chair also chairs the Trust's Members' Council meetings and ensures that there is effective communication between the Trust Board and the Members' Council and that the views of the Members' Council are sought and listened to.

The Chair and Non-Executive Directors are appointed by the Members' Council following a recruitment and selection process managed on its behalf by the Nominations Committee (see below). The Nominations Committee makes recommendations on the appointment or re-appointment of Non-Executive Directors to the Members' Council. The Members' Council also has the ability to remove Non-Executive Directors and the Chair from post.

Trust Board has a variety of individual skills and experience, which they bring to bear on the work of the Trust. Each director's experience is described below, along with any declaration of interest as at the end of March 2011:

| Role/name/appointment/declaration of interests | Experience |
|---|---|
| **Chair of the Trust and Members' Council**<br>Joyce Catterick<br>No interests declared<br>This has not changed during 2010/11<br>The Chair has no other significant commitments<br><br>Appointed 1 February 2008 to 31 January 2012 | ➢ Chair of successful Primary Care Trust 6 years. Taken through 'Fitness for Purpose' exercise<br>➢ 15 years NHS Board experience<br>➢ 6 years Trustee of National Charity and member of their Audit Committee<br>➢ Worked with Local Authority and NHS Partners to bring about organisational and service change<br>➢ Took Trust through successful Foundation Trust |

| Role/name/appointment/declaration of interests | Experience |
|---|---|
| | application |
| **Deputy Chair and Senior Independent Director**<br>Ian Black<br>➢ Non-Executive Director, McKeith Press Ltd.<br>➢ Owner, I&B Associates Limited<br>➢ Non-Executive Director Trustee and Treasurer, Scope Charity<br>➢ Governor, Beaumont College, Lancaster<br>➢ Private shareholding in Lloyds Banking Group (retired member of staff)<br>➢ Non-Executive Director, Benenden Healthcare<br>➢ Non-Executive Director and shareholder, Seedrs<br><br>Appointed as designate 20 March 2008<br>Substantive from 1 May 2008 to 30 April 2012<br>Deputy Chair from 1 June 2010 to 30 April 2012 | ➢ Chartered accountant and management consultant.<br>➢ 20 years at Halifax plc/HBoS with a series of director roles in customer service, operations, risk and finance in the UK, Ireland, continental Europe and Australia.<br>➢ Particular areas of experience in financial management and funding/investment<br>➢ Senior independent director and chair of Audit Committee for Nisa-Today's PLC.<br>➢ Treasurer (and ex-chair) of Scope (UK disability charity).<br>➢ Non-Executive Director of McKeith Press Limited<br>➢ Variety of charitable interests nationally and locally.<br>➢ School Governor for 6 years.<br>➢ Former pension fund Trustee<br>➢ Governor, Beaumont FE College, Lancaster |
| **Non-Executive Director (Chair of Audit Committee)**<br>Peter Aspinall<br>Directorships held in:<br>➢ Primrose Mill Ltd.<br>➢ Honley Show Society Ltd.<br><br>Appointed as designate 1 November 2008 for an initial period of 12 months.<br>Appointed by Members' Council from 1 May 2009 to 30 April 2012 | ➢ Over 20 years of Board and Leadership Team experience.<br>➢ Finance Director in a number of significant manufacturing and commercial organisations including complex multinational environments.<br>➢ Membership of integration and change management experience gained resultant to significant merger. |
| **Non-Executive Director**<br>Bernard Fee<br>No interests declared<br><br>Appointed as designate 20 March 2008<br>Substantive from 26 May 2008 to 26 May 2011<br>Re-appointed 27 May 2011 to 26 May 2014 | ➢ Strong leadership and development background.<br>➢ Leading large teams at different levels through strong, focused performance management.<br>➢ Driving results through people and encouraging individuals to maximise potential. |
| **Non-Executive Director**<br>Jonathan Jones<br>➢ Director, Squire, Sanders and Dempsey International Association<br>➢ Member, Squire, Sanders and Dempsey (UK) LLP<br><br>Appointed 1 June 2010 to 31 May 2013 | ➢ Solicitor<br>➢ Member of the Global Board of Squire, Sanders & Dempsey |
| **Non-Executive Director**<br>Helen Wollaston<br>➢ Owner/Director, Equal to the Occasion<br>➢ Chair, Platform 51 (operating name of YWCA England and Wales)<br>➢ Consultant Partner, Equality Works<br>➢ Associate, Infrastruct Ltd.<br><br>Appointed 1 August 2009 to 31 July 2012 | ➢ Over 20 years experience working on equality and diversity in the public and voluntary sectors<br>➢ Founder/Director Equal to the Occasion, a consultancy to support equality and diversity projects. Special interest in empowering Muslim women and capacity building voluntary sector in disadvantaged communities<br>➢ 7 years as Director of Campaigns at Equal Opportunities Commission<br>➢ 3 years as Regional Manager of National Lottery Charities Board in Yorkshire and the Humber<br>➢ Chair of Platform 51 (a charity working with women and girls across England and Wales)<br>➢ Member of West Yorkshire Criminal Justice Board Diversity Panel (to March 2011)<br>➢ Steering group member of Kirklees Lesbian Gay Bisexual and Transgender community network |
| **Chief Executive**<br>Steven Michael<br>➢ Member of Huddersfield University Business School Advisory Board | ➢ Occupied role of Accountable/Accounting Officer from February 2007 leading the Trust to Foundation Trust status in May 2009 |

| Role/name/appointment/declaration of interests | Experience |
|---|---|
| ➢ Member, Leeds University International Fellowship Scheme<br>➢ Spouse is Trustee of the Harrison Trust, a charitable body supporting mental health in the Wakefield district<br><br>Appointed 1 April 2002<br>Acting Chief Executive from 4 September 2006<br>Chief Executive from 12 February 2007<br>(Secondment to DoH 1 October 2010 to 31 January 2011) | ➢ 25 years experience in the NHS with Executive Director experience since 2000<br>➢ Significant clinical leadership experience both as nurse leader and clinical director at key points in career<br>➢ Experience in working in not for profit sector at senior management level<br>➢ Partnership working over two decades including chairing of partnership boards<br>➢ Track record in project management including large and complex capital projects<br>➢ Strong record in contract and planning negotiation with commissioners<br>➢ Experience in working at both regional and national level including recent secondment as Regional Director of Provider Development for Yorkshire and the Humber<br>➢ Long history of effective engagement with service users and carers<br>➢ Record in working with a range of universities including Newcastle-upon-Tyne, Northumbria, Huddersfield and Leeds |
| **Deputy Chief Executive/Director of Finance**<br>Alex Farrell<br>➢ Spouse is general practitioner based in Beeston, Leeds<br><br>Appointed 7 September 2009<br>(Acting Chief Executive 1 October 2010 to 31 January 2011) | ➢ Qualified medical Doctor<br>➢ Retrained in private sector as Chartered Accountant<br>➢ Rejoined Health service in acute sector, and has worked in Health Authority, PCG and PCTs in senior management.<br>➢ 5 years experience as a Director of Finance. Last 4 years based in West Yorkshire PCTs with portfolio experience in strategic financial planning and management; contract negotiation and healthcare tenders; developing Estates Strategy and capital business cases ;developing IM & T Strategy and implementation of performance framework based on Balanced scorecard; implementation of Integrated Governance and working with GP stakeholder to implement Practice Based Commissioning.<br>➢ Bring a good understanding of Commissioning, performance management and governance to support the development of the FT. |
| **Medical Director**<br>Nisreen Booya<br>➢ Honorary President of the Support to Recovery (Kirklees mental health charity)<br>➢ Facilitator, medical student programme, Leeds University<br><br>Appointed 29 January 2004 | ➢ Clinical experience as Consultant Psychiatrist since 1985 in both WAA and OPS<br>➢ Experience in service planning, development and innovative service models.<br>➢ Experience in medical education, training, assessment, appraisal and management.<br>➢ Experience in clinical governance (CGR reviewer with CHI and HCC standards development and independent reviews).<br>➢ Interest in performance indicators and outcome measures in mental health<br>➢ Interest in long term conditions in mental health |
| **Director of Human Resources and Workforce Development**<br>Alan Davis<br>No interests declared<br><br>Appointed 1 April 2002 | ➢ 27 years experience of HR in the NHS<br>➢ 18 years as an Executive Director of Trust<br>➢ Human Resource Management<br>➢ Leadership and Workforce Development<br>➢ Business Planning<br>➢ Staff Side/Staff Engagement/Consultation<br>➢ Chair Childcare Information Service Ltd 10 years (charity providing services to local authorities)<br>➢ Employee Relations |

| Role/name/appointment/declaration of interests | Experience |
|---|---|
| | ➢ Investor in People<br>➢ Member of the Director team leading FT application SWYPFT<br>➢ 2009 runner up in NHS HR Director of the Year: nominated by Chief Executive and Staff Side Organisations |
| **Acting Director of Nursing, Compliance and Innovation**<br>Gill Green<br>➢ Trustee, Well Women Centre, Wakefield<br><br>Appointed 3 December 2009 | ➢ 25 years experience of nurse leadership and operational delivery in different NHS organisations<br>➢ Development of delivery of new services and re-engineering services<br>➢ Delivering direct nursing care in a variety of acute and mental health settings<br>➢ Experience of Trustee positions in third sector organisations<br>➢ Development and implementation of strategies and policies |
| **Director of Corporate Development (Company Secretary) non-voting**<br>Dawn Stephenson<br>➢ Voluntary Trustee for Kirklees Active Leisure<br>➢ Voluntary Trustee for Dr. Jackson Cancer Fund<br><br>Secondment 8 February 2010<br>Substantive appointment from 1 April 2011 | ➢ 14 years experience at Board level as an NHS Director<br>➢ Knowledge of community, primary care and acute through previous experience as Director of Finance and Chief Executive in an integrated trust and primary care trust.<br>➢ Board governance<br>➢ Risk management<br>➢ Public involvement<br>➢ Communications<br>➢ Partnership working |
| **Director of Nursing, Compliance and Innovation (non-voting)**<br>Noreen Young<br>No interests declared<br><br>Appointed 1 November 2007 | ➢ 33 years experience in Mental Health care, also regional and national working<br>➢ 8 years working as an Executive Director of Nursing plus Deputy CEO/COO experience<br>➢ 2 years general manager responsible for city-wide older persons' services.<br>➢ Experience in operational management, professional development leading culture change, research and education<br>➢ Experience in governance, risk management, quality, organisational development and service redesign systems<br>➢ Experience in managing patient safety systems<br>➢ Experience in developing service user/carer engagement<br>➢ National leadership/ward manager development facilitator<br>➢ Royal College of Nursing leadership facilitation<br>➢ Regional leading and empowering organisation facilitator |
| **District Service Director – Calderdale and Kirklees (non-voting)**<br>Anna Basford<br>No interests declared<br><br>Appointed 1 November 2010 | ➢ 1991 Certificate of Managing Health Services (Institute of Health Services Management)<br>➢ 1992 NHS General Management Training (Manchester Business School)<br>➢ 2008 Executive Officer Patient Safety Training (Institute of Healthcare Improvement, Boston)<br>➢ 2009 Emergency Planning (NHS North West and Department of Health)<br>➢ 2009 Attaining Leadership Excellence – Executive Stretch (University of Leeds)<br>➢ 2009 QIPP Master Classes and Executive coaching (NHS North West Leadership Academy)<br>➢ 2011 NHS Foundation Trust Commercial Directors' Development Programme (CASS Business School, City University, London |

| Role/name/appointment/declaration of interests | Experience |
|---|---|
| **Director of Forensic Services (non-voting)**<br>Adrian Berry<br>No interests declared<br><br>Appointed 1 November 2010 | ➢ 14 years experience of clinical care as consultant forensic psychiatrist and of training specialist registrars<br>➢ Leader of clinical management team 1999-2003<br>➢ Associate medical director and Trust Board member 2003-2005<br>➢ Program director for specialist forensic training in Yorkshire and Humber 2006-2009<br>➢ Clinical project lead for a number of capital projects and service developments<br>➢ Contract management and negotiation experience with specialist commissioning team |
| **District Service Director – Wakefield (non-voting)**<br>Tim Breedon<br>No interests declared<br><br>Appointed 1 November 2010 | ➢ Over 25 years experience in the health and social care market with both public and private sector experience.<br>➢ Executive Director experience in both public and private sector environments, including Managing Director of a Long Term Health Care PLC.<br>➢ Significant senior management experience in both local authority and charitable sector at key points in career.<br>➢ Five years experience as a self-employed management and training consultant.<br>➢ Director level responsibility for PLC acquisition and merger plan.<br>➢ Significant experience in contract negotiation and delivery on contracts, including the delivery of capital investment programme to support growth.<br>➢ Lead professional adviser on learning disability policy, strategy and commissioning for both PCT and local authority.<br>➢ Well documented history of partnership working, including the chairing of multi-agency partnership boards. |

The following members of Trust Board left office during 2010/11.

| Role/name/appointment/declaration of interests | Experience |
|---|---|
| **Deputy Chair and Senior Independent Director**<br>Jan Wilson (to 26 May 2010)<br>➢ Lay Chair, Yorkshire Deanery<br>➢ Member, Regional Sub-Committee, Advisory Committee on Clinical Excellence Awards<br>➢ Public Appointments Ambassador Network through Government Equalities Office<br><br>Appointed 27 May 2002, re-appointed 27 May 2006 and 27 May 2008 to 26 May 2010<br>Deputy Chair from 1 June 2006 for 2 years, extended to 31 March 2009.<br>Acting Chair 1 October 2007 to 31 January 2008 | ➢ Implementation of NHS & Community Care Act (Strategy & Policy)<br>➢ Staff development and training, NVQ assessment centre<br>➢ Joint commissioning and contracting in Social Services & NHS<br>➢ Registration regulation compliance and complaints for social care<br>➢ Inspection of Residential/Nursing Homes/Domiciliary Care (CSCI)<br>➢ Voluntary sector management and Committee member<br>➢ School governor (Vice Chair)<br>➢ Management & control of large public sector budgets<br>➢ Performance management, appraisals, disciplinaries, recruitment<br>➢ Policy development at local, regional and national level<br>➢ Nine years as a Non-Executive Director (HA, PCG, NHS Trust)<br>➢ Social Enterprise schemes<br>➢ High performing boards (Audit Commission)<br>➢ Junior Doctor training interviews (Lay Chair |

| Role/name/appointment/declaration of interests | Experience |
|---|---|
| | Yorkshire Deanery)<br>➢ Consultant / Executive Officer interviews<br>➢ HR Appeals |
| **Non-Executive Director**<br>Anne Gregory (to 26 May 2010)<br>➢ Director, Centre for Public Relations Studies, wholly owned by Leeds Metropolitan University, which has a number of contracts with the Department of Health<br>➢ Contract with NHS East Midlands to deliver Masters course<br>➢ Contract with NHS Yorkshire and the Humber to deliver Masters course<br>➢ Contract with NHS Institute for Innovation and Improvement to deliver Graduate Diploma<br>➢ Contract with NHS Yorkshire and the Humber to deliver evaluation system<br>➢ Council Member, Chartered Institute of Public Relations (Director) who will seek business with the NHS<br>➢ Leeds Metropolitan University (employer) will seek to do business with the Trust<br><br>Appointed 27 May 2002, re-appointed 26 May to 26 May 2008 and 27 May 2008 to 26 May 2010 | ➢ Pro-Vice-Chancellor of UK's largest Teaching University<br>➢ 8 years as Director of University Consultancy Centre<br>➢ 6 years as Assistant Dean at Europe's largest Business School<br>➢ 2 years as company director<br>➢ 5 years as manager in Financial Services industry<br>➢ 11 years working as non-executive director in NHS in two difference trusts<br>➢ Expertise in organisational strategic direction, leadership, business planning, staff development, business development, management communication, partnership development |
| **Director of Business Development and Planning**<br>Terry Dutchburn (to 30 November 2010)<br>➢ Spouse is Assistant Director of Commissioning at NHS Kirklees<br><br>Appointed 1 June 2007<br>Left 30 November 2010 | ➢ 3 years as Commissioning Director in a PCT<br>➢ 32 years experience in NHS, 24 in mental health services as senior manager and clinician<br>➢ Recent extensive experience in leading the implementation of NHS system reform<br>➢ Strong record in partnership development<br>➢ Significant experience of commissioning & contract negotiations<br>➢ Experience of working with Primary Care and GPs |
| **Director of Corporate Development**<br>Ruth Unwin (to 30 September 2010)<br>No interests declared<br><br>Appointed 1 April 2002<br>Secondment to Mid-Yorkshire Hospitals NHS Trust from 1 February 2010<br>Left the Trust 30 September 2010 | ➢ 12 years' experience as an NHS Director<br>➢ 15 years experience of working in a senior management role in the NHS<br>➢ Extensive knowledge of the local environment through working as a journalist for ten years<br>➢ Public involvement<br>➢ Communications<br>➢ Risk Management<br>➢ Previous experience as Board secretary<br>➢ Experience of managing communications and engagement through major change<br>➢ Experience of running engagement and consultation processes with diverse stakeholders |
| **Acting Director of Finance**<br>Cherrine Hawkins (to 31 January 2011)<br>➢ Spouse is owner of Geoff Clegg Ltd. (lifting gear company) – unlikely to do business directly with the NHS but may supply to a third part contactor.<br>➢ Company Secretary, Geoff Clegg Ltd.<br><br>Acting Director of Finance from 1 October 2010 to 31 January 2011 | ➢ Experience in financial management and accounting. |

The Trust regularly reviews the balance, completeness and appropriateness of its Board to meet the requirements of a Foundation Trust and of a unitary board. Where appropriate, the Trust will look to recruit individuals with certain skills and experience to ensure that this is maintained. The Trust involves its Members' Council in this process through the Nominations Committee.

Individual performance of members of Trust Board is assessed as follows.

- The Deputy Chair/Senior Independent Director, with support from Non-Executive and Executive Directors and the Members' Council, has a process in place to appraise the Chair annually. The outcome of this appraisal is reported to the Members' Council.
- The Chair of the Trust undertakes quarterly reviews with Non-Executive Directors.
- The Chair of the Trust also undertakes quarterly reviews with the Chief Executive.
- The Chief Executive undertakes quarterly reviews of performance against objectives with Executive Directors and his Executive Management Team.

There are no Executive Directors serving as Non-Executive Directors elsewhere.

Attendance at Board meetings 2010/11

| Name | 27/04 B&R | 25/05 B&R | 29/06 Pub | 27/07 B&R | 28/09 Pub | 26/10 B&R | 30/11 Strat | 14/12 Pub | 7/01 B&R | 25/01 B&R | 22/02 B&R | 29/03 Pub |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CATTERICK, Joyce | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ASPINALL, Peter | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| BLACK, Ian | ✓ | ✓ | ✓ | ✓ | ✓ | ✖ | ✓ | ✓ | ✓ | ✓ | ✖ | ✓ |
| FEE, Bernard | ✖ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✖ | ✖ | ✓ | ✓ |
| GREGORY, Anne | ✓ | ✓ | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| JONES, Jonathan | N/A | N/A | ✓ | ✖ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| WILSON, Jan | ✓ | ✖ | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| WOLLASTON, Helen | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| MICHAEL, Steven | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| BASFORD, Anna | N/A | N/A | N/A | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| BERRY, Adrian | N/A | N/A | N/A | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✖ |
| BOOYA, Nisreen | ✓ | ✖ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| BREEDON, Tim | N/A | N/A | N/A | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| DAVIS, Alan | ✖ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| DUTCHBURN, Terry | ✓ | ✓ | ✓ | ✓ | ✖ | ✖ | ✖ | N/A | N/A | N/A | N/A | N/A |
| FARRELL, Alex | ✓ | ✓ | ✓ | ✖ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| GREEN, Gill | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✖ |
| HAWKINS, Cherrine | N/A | N/A | N/A | N/A | N/A | ✖ | ✓ | ✓ | ✓ | ✓ | N/A | N/A |
| STEPHENSON, Dawn | ✓ | ✓ | ✖ | ✓ | ✓ | ✓ | ✓ | ✖ | ✓ | ✓ | ✓ | ✓ |
| UNWIN, Ruth | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| YOUNG, Noreen | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

## Trust Board Committees

Trust Board discharges its responsibilities through a number of Committees. The membership and work of the Trust's key committees is outlined below.

The Director of Corporate Development attends all Committee meetings, with the exception of the Remuneration and Terms of Service Committee, as part of her role as Company Secretary. The Chair of the Trust and the Chair of the Audit Committee attend at least one

meeting of each Committee per year as part of the review of the effectiveness of Non-Executive Directors individually and of the Committees.

## Audit Committee

The Audit Committee's prime purpose is to keep an overview of the systems and processes that provide controls assurance and governance within the organisation as described in the Statement of Internal Control on behalf of Trust Board and that these systems and processes used to produce information taken to Trust Board are sound, valid and complete. This includes ensuring independent verification on systems for risk management and scrutiny of the management of finance.

Members during 2010/11

| | |
|---|---|
| Peter Aspinall, Non-Executive Director (Chair from July 2010) | Attended five out of five meetings |
| Ian Black, Non-Executive Director (Chair to July 2010) | Attended five out of five meetings |
| Bernard Fee, Non-Executive Director (member from June 2010) | Attended four out of four meetings |
| Anne Gregory, Non-Executive Director (member to May 2010) | Attended one out of one meeting |
| Jan Wilson, Non-Executive Director (member to May 2010) | Attended one out of one meeting |
| Helen Wollaston, Non-Executive Director (member to May 2010) | Attended none out of one meeting |

The Audit Committee produces an annual report each year, which provides assurance to Trust Board that it has fulfilled its roles and responsibilities under its terms of reference. The following is an outline of how the Committee has done this in 2010/11.

1. Internal Audit

The Committee shall ensure that there is an effective internal audit function, established by management, that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board as follows.

| | **Progress** |
|---|---|
| Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal. | The Audit Committee reviewed the performance of Internal Audit performance in July 2010, which indicated an improvement in service provision over 2009/10. There are no plans to alter provision of service in the short term. A further review will take place in July 2011. |
| Review and approval of the Internal Audit strategy, programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework. | The Internal Audit Annual Plan for 2010/11 was agreed by the Audit Committee in July 2010. Progress against the plan is reviewed at every meeting. Regular meetings are held with the Director of Finance to monitor progress on the work plan. |
| Consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources. | The Committee receives the audit reports and audit findings in line with the audit plan. The recommendations are followed up to ensure actions are taken in line with the action plans agreed. There are no significant outstanding actions. |
| | The Audit Committee reviewed and received the Head of Internal Audit Opinion as part of the final accounts process for 2009/10. |
| Ensure the Internal Audit function is adequately resourced and has appropriate standing in the organisation. | The adequacy of resources is assessed through review of the plan and monitoring rate of achievement. No significant issues raised in year. |
| An annual review of the effectiveness of internal audit. | Internal Audit produced an Annual report for 2009/10. The Annual review of Internal Audit for |

| | |
|---|---|
| | **Progress**<br>2009/10 was presented to the Audit Committee in July 2010. This was the first opportunity to complete this requirement (see 1 above). |

## 2. Counter Fraud

The Committee shall ensure that there is an effective counter fraud service, established by management, that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.

| | **Progress** |
|---|---|
| Consideration of the provision of the Counter Fraud service, the cost of the audit and any questions of resignation and dismissal. | The Counter Fraud service is contracted through West Yorkshire Audit Consortium. |
| Review and approval of the Counter Fraud strategy, programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework. | The Counter Fraud Risk Assessment and Annual Plan for 2009/10 was agreed by the Audit Committee in July 2010. Progress against plan is reviewed at every meeting. |
| Consideration of the major findings of Counter Fraud (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources. | The Committee receives the Counter Fraud update report at each meeting to identify progress and any significant issues for action. It is pleasing to note that the number of referrals and investigations has increased in 2009/10 indicating increased awareness of counter fraud both within the organisation and independent contractors. |
| An annual review of the effectiveness of Counter Fraud Services. | The Trust received a rating of 2 out of 4 from the external evaluation of Compound Indicators for 2009/10 which would support adequate performance in this area. This was reported to the Audit Committee in February 2011. The evidence for external assessment for 2010/11 will be submitted by the end of April 2011. |

## 3. External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Audit Commission and consider the implications and management's responses to their work. This will be achieved as follows.

| | **Progress** |
|---|---|
| Consideration of the appointment and performance of the External Auditor, as far as the Audit Commission's rules permit. | As a Foundation Trust, the Members' Council is responsible for the appointment of the Trust's external auditor. Previously the appointment of external auditors was governed by the Audit Commission. The Audit Committee recommended to the Members' Council in May 2009 that the current external auditors were retained for the first year of Foundation Trust status. The recommendation was accepted. The Trust undertook a formal tender process for External Audit during 2010 and awarded the contract in October 2010 to Deloitte. |
| Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy. | The Audit Committee has received and approved the Annual Audit Plan. Progress against plan is monitored at each meeting. |

| | **Progress** |
|---|---|
| Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee. | The Audit Committee received and approved the Audit Plan and fee for Grant Thornton from April to October 2010. The Audit Plan and fee for Deloitte was approved by the Committee in February 2011. |
| Review all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses. | The Audit Committee received and approved:<br>➢ the Annual Audit letter 2009/10 for the one month the Trust was a Foundation Trust in that financial year;<br>➢ the statement for those with responsibility for governance in relation to 2009/10 accounts;<br>➢ final reports and recommendations as scheduled in the annual plan;<br>➢ Auditor's Local Evaluation report for 2009/10 (ALE). |

The Committee also reports on the following items as standing items at each meeting to provide assurance to the Board that the Trust has complied with Trust regulations and Standing Orders.

- Review of internal audit progress reports.
- Review of losses and special payments.
- Review of counter fraud progress report.
- Review of external audit activity.
- Procurement report, which monitors non-pay spend and progress on tenders.
- Triangulation report of risk, performance and governance.

The Committee is also required to receive a report on any waiver of Standing Orders. During 2010/11, there have been no instances to report.

In discharging its duties in relation to financial reporting the Committee has also received the following reports as part of its remit.

- Received and approved annual accounts and annual report for 2009/10.
- Received and approved the annual accounts and annual report for Charitable Funds for 2009/10.
- Received the report from External Audit (ISA260) for those charged with governance, which outlines findings of external audit.
- Reviewed Annual Audit letter for 2009/10 for the one month in the financial year that the Trust was an NHS Trust.
- Review of Standing Orders, Standing Financial Instructions and Scheme of Delegation.
- Agreement of revision of accounting policies to comply with International Financial Reporting Standards (IFRS).
- Review of the external audit report on the production of Quality Accounts for 2009/10. The scrutiny of the Quality Accounts themselves is a responsibility of the Clinical Governance and Clinical Safety Committee.
- Reviewed the implementation of the ALE action plan and Use of Resources Assessment for 2009/10 and consideration of future arrangements for assessing value for money as a Foundation Trust.
- Reviewed the impact of implementing IFRS on the accounting policies and financial statements of the Trust.

The Chair of the Audit Committee ensures any issues are brought to the attention of Trust Board. In particular, this could include any major breakdown in internal control that has led to significant loss or any major weaknesses in the governance systems that exposes the

organisation to unacceptable risk. There have been no such issues during this financial year.

In line with recommended best practice the Audit Committee provides the following assurance to Trust Board:

- The Statement of Internal Control in consistent with the view of the Committee.
- Whilst the committee is not responsible for overall risk management within the Trust, it is satisfied that the system of risk management in the organisation is adequate.
- The Assurance Framework is reviewed by Trust Board quarterly and is considered to be fit for purpose. The Committee can assure Trust Board that it believes the processes for consideration and approval to be adequate.
- That there are no areas of significant duplication or omissions in the systems of governance in the organisation that have come to the Committee's attention, which have not been adequately resolved.

During 2010/11, in agreement with and supported by, the Members' Council, the Audit Committee led a process to tender for external audit arrangements for the Trust. As a result of this exercise, up to 30 September 2010, external audit services were provided by Grant Thornton. From 1 October 2010, these services were provided by Deloitte. This decision was approved by the Members' Council.

The following non-audit services were provided during 2010/11 by Grant Thornton:

- Value for Money review, and
- Single Point of Access scoping exercise.

To maintain auditor objectivity, independence and probity, these services are carried out by Grant Thornton staff who are not involved in the Trust statutory audits, nor do the audit staff have any involvement with the findings, which are reported directly to the Trust and not via the audit partner.

## Clinical Governance and Clinical Safety Committee

The Clinical Governance and Clinical Safety Committee provides assurance to Trust Board on service quality and the application of controls assurance in relation to clinical services. It scrutinises the systems in place for effective care co-ordination and evidence-based practice and focuses on quality improvement to ensure a co-ordinated holistic approach to clinical risk management and clinical governance is in place, protecting standards of clinical and professional practice

Members during 2010/11

| | |
|---|---|
| Ian Black, Non-Executive Director (member from June 2010) | Attended four out of four meetings |
| Bernard Fee, Non-Executive Director (Chair) | Attended five out of five meetings |
| Anne Gregory, Non-Executive Director (member to May 2010) | Attended one out of one meeting |
| Jan Wilson, Non-Executive Director (member to May 2010) | Attended one out of one meeting |
| Helen Wollaston, Non-Executive Director (member from June 2010) | Attended three out of four one meetings |
| Nisreen Booya, Medical Director | Attended five out of five meetings |
| Alan Davis, Director of Human Resources and Workforce Development (member from February 2011) | Attended one out of one meeting |
| Gill Green, Acting Director of Nursing, Compliance and Innovation (lead Director) | Attended five out of five meetings |
| Noreen Young, Director of Nursing, Compliance and Innovation | Attended two out of five meetings |

## Mental Health Act Committee

The Mental Health Act Committee is responsible for ensuring the organisation is working within the legal requirements of the Mental Health Act (1983), as amended by the 2007 Act and Mental Capacity Act 2005, and with reference to guiding principles as set out in the Code of Practice.

| | |
|---|---|
| Peter Aspinall, Non-Executive Director (member to May 2010) | Attended one out of one meeting |
| Bernard Fee, Non-Executive Director | Attended three out of three meetings |
| Jonathan Jones, Non-Executive Director (member from August 2010) | Attended one out of two meetings |
| Jan Wilson, Non-Executive Director (Chair and member to May 2010) | Attended none out of one meeting |
| Helen Wollaston, Non-Executive Director (Chair from June 2010) | Attended three out of three meetings |
| Nisreen Booya, Medical Director | Attended three out of three meetings |
| Gill Green, Acting Director of Nursing, Compliance and Innovation (lead Director) | Attended three out of three meetings |

## Remuneration report

The Remuneration and Terms of Service Committee has delegated authority for developing and determining appropriate pay and reward packages for the Chief Executive, Executive Directors and senior staff within the Trust that actively contribute to the achievement of the Trust's aims and objectives. The Committee also has delegated authority to approve any termination payments for the Chief Executive, Executive Directors and senior staff and is responsible for ratifying Clinical Excellence Awards for Consultant Medical Staff. The Committee also scrutinises workforce and HR performance on behalf of Trust Board.

| | |
|---|---|
| Peter Aspinall, Non-Executive Director (Chair and member to May 2010) | Attended one out of one meeting |
| Ian Black, Non-Executive Director (Chair and member from September 2010) | Attended three out of three meetings |
| Joyce Catterick, Chair of the Trust | Attended four out of four meetings |
| Jonathan Jones, Non-Executive Director (member from September 2010) | Attended three out of three meetings |
| Jan Wilson, Non-Executive Director (member to May 2010) | Attended none out of one meeting |
| Helen Wollaston, Non-Executive Director | Attended three out of four meetings |
| Steven Michael, Chief Executive (non-voting member) | Attended four out of four meetings |

The Chief Executive and Executive Directors are appointed by the Remuneration and Terms of Service Committee on behalf of Trust Board. These appointments are ratified by the Members' Council. Trust Board will agree an appropriate appointment process to suit the needs of the appointment and the Trust. Directors' remuneration is also determined by this committee.

Alan Davis, Director of Human Resources and Workforce Development, provides advice and guidance to the Committee, and the Committee is provided with administrative support by the Integrated Governance Manager. The Committee used the HAY Group report commissioned in 2009/10, which provided an independent review of the remuneration arrangements for directors, using a job evaluation system and a public sector comparison, to consolidate Directors' pay scales. This was the only external advice used by the Committee during the year.

During the year, the Committee approved a performance related pay scheme for Directors based on the achievement of a mix of key corporate and challenging individual objectives agreed between the Chief Executive and Directors individually, and, in the case of the Chief Executive, between the Chair and Chief Executive, designed to recognise the overall performance of the Trust combined with the performance of individual Directors. The criteria for these performance measures were approved by the Committee and monitored quarterly through individual performance reviews undertaken by the Chief Executive and the Chair. The scheme was set in a clear framework within pay arrangements for Directors identified by an external review undertaken by the Hay Group during 2010. This review took account of public sector comparators and Agenda for Change rates are part of its recommendations.

The scheme comprised two elements of three gateway corporate objectives against which the Trust's performance is assessed and nine personal objectives for each director against which their individual performance is assessed. All three gateway corporate objectives must be achieved before any performance awards can be made. The achievement of all three objectives above will give a performance award of 1.5% of base salary for each director. In addition to the corporate award individual directors can receive an additional performance award based on achievement of personal objectives. A set of nine personal objectives have been agreed for directors (including the Chief Executive), which could attract up to 0.5% of base salary for each objective.

The Remuneration and Terms of Service Committee approved the outcome of the Scheme; however, the offer of additional payment achieved through successful delivery of measurable objectives was declined by the Chief Executive and it will be for Directors make a decision on an individual basis.

The policy of the Trust remains that its terms and conditions for staff reflect nationally determined arrangements. However, the Committee has agreed to review the employer-based Clinical Excellence Award scheme to develop a stronger connection with Trust priorities, review speciality doctor recruitment and explore the potential of local remuneration arrangements for this group, which could support recruitment and retention, and undertake a feasibility study for bringing senior manager posts out of Agenda for Change.

During the year, the Committee approved two business cases for redundancy termination for a director and for a senior member of staff in the interests of the Trust. There were no significant awards made to past senior managers.

Details of the appointment dates for Non-Executive and Executive Directors of the Trust are included in the table above. Non-Executive Directors are usually appointed for a three-year term and can be re-appointed for further terms up to a maximum of nine years. There are no Executive Directors appointed on fixed term contracts. All Executive Directors are subject to a three-month notice period. No provision for compensation for early termination is included in staff contracts and any provision for compensation for termination would be considered on an individual basis by the Committee.

Steven Michael
**Chief Executive**

**37 Salary and Pension entitlements of senior managers**

**37.1 Remuneration**

The Salary and Pension entitlements of senior managers are set by the 'Remuneration and Terms of Services Committee' which is a sub-committee of the Trust Board. The members of this committee in 2010/11 were Joyce Catterick (Chair of the Trust Board), Peter Aspinall (Chair of the Committee until 31 May 2010 and Non-Executive Director of the Trust), Ian Black (Chair of the Committee from 01 June 2010 and Non-Executive Director of the Trust) Jan Wilson (Non-Executive Director of the Trust, left 26 May 2010), Jonathan Jones (member of the Committee from 1 September 2010 and Non-Executive Director of the Trust), Helen Wollaston (Non-Executive Director of the Trust), Steven Michael (Chief Executive) with Alan Davis (Director of Human Resources & Workforce Development) in attendance and Bernie Cherriman-Sykes who is the committee secretary.
The Trust follows national guidance on pay and terms and conditions for Senior Managers and the contracts are substantive contracts with NHS termination arrangements.

| Name and Title | Twelve Months to 31/03/2011 | | | Eleven Months to 31/03/2010 | | |
|---|---|---|---|---|---|---|
| | Salary (bands of £5000) £000 | Other Remuneration (bands of £5000) £000 | Benefits in Kind Rounded to 1 decimal place £000 | Salary (bands of £5000) £000 | Other Remuneration (bands of £5000) £000 | Benefits in Kind Rounded to 1 decimal place £000 |
| Joyce Margaret Catterick, Chair | 40 - 45 | | | 35 - 40 | | |
| Janice Anne Wilson, Non-Executive Director (left 26/05/2010) | 0 - 5 | | | 15 - 20 | | |
| Bernard Fee, Non-Executive Director | 10 - 15 | | | 10 - 15 | | |
| Ian Black, Non-Executive Director | 15 - 20 | | | 15 - 20 | | |
| Peter Aspinall, Non-Executive Director | 15 - 20 | | | 10 - 15 | | |
| Anne Gregory, Non-Executive Director (left 26/05/2010) | 0 - 5 | | | 10 - 15 | | |
| Jonathan Jones, Non-Executive Director (appointed 01/06/2010) | 10 - 15 | | | | | |
| Helen Wollaston, Non-Executive Director | 10 - 15 | | | 5 - 10 | | |
| Steven Peter Michael, Chief Executive | 135 - 140 | | 3.5 | 125 - 130 | | 3.4 |
| Nisreen Hanna Booya, Medical Director | 20 - 25 | 115 - 120 | | 25 - 30 | 150 - 155 | |
| Alan George Davis, Director of Human Resources and Workforce Development | 90 - 95 | | 0.9 | 75 - 80 | | 0.9 |
| Terrence Dutchburn, Director of Business Development and Planning (left 30/11/2010) | 55 - 60 | 360 - 365 | 2.6 | 80 - 85 | | 3.8 |
| Hazel O'Hara, Chief Operating Officer (left 31/01/2010) | | | | 75 - 80 | 45 - 50 | 1.2 |
| John Scampion, Interim Director of Finance (left 04/09/2009) | | | | 55 - 60 | | |
| Alexandra Farrell, Deputy Chief Executive/Director of Finance and Acting Chief Executive (from 01/10/2010 to | 100 - 105 | | | 55 - 60 | | |
| Dawn Stephenson, Director of Corporate Development | 125 - 130 | | | 20 - 25 | | |
| Ruth Unwin, Director of Corporate Development (left 31/01/2010) | | | | 60 - 65 | | 7.0 |
| Gillian Green, Acting Director of Nursing, Compliance and Innovation | 80 - 85 | | 0.6 | 25 - 30 | | 0.3 |
| Noreen Young, Director of Nursing, Compliance and Innovation | 80 - 85 | | | 75 - 80 | | 25.9 |
| Cherrine Hawkins, Acting Director of Finance (from 01/10/2010 to 31/01/2011) | 25 - 30 | | | | | |
| Timothy Breedon, District Service Director, Wakefield (appointed 01/11/2010) | 30 - 35 | | | | | |
| Anna Basford, District Service Director, Calderdale and Kirklees appointed (01/11/2010) | 35 - 40 | | 5.1 | | | |
| Adrian Berry, Director of Forensic Services (appointed 01/11/2010) | 10 - 15 | 40 - 45 | 1.1 | | | |

The benefits in kind relate to either staff lease cars or expenses paid in accordance with the Trust's Removal Expenses Policy (which includes provision of accommodation), child care vouchers and relocation expenses.
Other remuneration for Terrence Dutchburn includes £341k of pension enhancements paid to the NHS Pensions Authority as part of an exit package.
Dawn Stephenson was seconded from Mid Yorkshire Hospital Trust during 2010/11.

.....Chief Executive.....Date

**37.2 Pension Benefits**

| Name and title | | Real increase/ (decrease) in pension and related lump sum at age 60 (bands of £2500) £000 | Total accrued pension and related lump sum at age 60 at 31 March 2011 (bands of £5000) £000 | Cash Equivalent Transfer Value at 31 March 2011 £000 | Cash Equivalent Transfer Value at 31 March 2010 £000 | Real Increase in Cash Equivalent Transfer Value £000 | Employers Contribution to Stakeholder Pension Rounded to 1 decimal place £000 |
|---|---|---|---|---|---|---|---|
| Steven Peter Michael, Chief Executive | | **7.5 - 10.0** | **175 - 180** | **694** | **757** | (44) | 0 |
| Nisreen Hanna Booya, Medical Director * | | **5.0 - 7.5** | **325 - 330** | **0** | **1,937** | 0 | 0 |
| Alan George Davis, Director of Human Resources and Workforce Development | | **10.0 - 12.5** | **125 - 130** | **563** | **575** | (8) | 0 |
| Terrence Dutchburn, Director of Business Development and Planning (left 30/11/2010) ** | | **5.0 - 7.5** | **145 - 150** | **0** | **637** | 0 | 0 |
| Alexandra Farrell, Deputy Chief Executive/Director of Finance and Acting Chief Executive (from 01/10/2010 to 31/01/2011) | | **10.0 - 12.5** | **95 - 100** | **392** | **388** | 3 | 0 |
| Dawn Stephenson, Director of Corporate Development (appointed 8/02/2010) | | **7.5 - 10.0** | **175 - 180** | **740** | **784** | (31) | 0 |
| Ruth Unwin, Director of Corporate Development (left 31/01/2010) | | | | | **302** | | 0 |
| Gillian Green, Acting Director of Nursing, Compliance and Innovation | | **17.5 - 20.0** | **105 - 110** | **479** | **438** | 28 | 0 |
| Noreen Young, Director of Nursing, Compliance and Innovation | | **0.0 - 2.5** | **170 - 175** | **795** | **869** | (51) | 0 |
| Cherrine Hawkins, Acting Director of Finance (from 01/10/2010 to 31/01/2011) | | **2.5 - 5.0** | **95 - 100** | **404** | **408** | (1) | 0 |
| Timothy Breedon, District Service Director, Wakefield (appointed 01/11/2010) | | **(12.5 - 15.0)** | **20 - 25** | **255** | **288** | (9) | 0 |
| Anna Basford, District Service Director, Calderdale and Kirklees (appointed 01/11/2010) | | **2.5 - 5.0** | **60 - 65** | **225** | **232** | (2) | 0 |
| Adrian Berry, Director of Forensic Services (appointed 01/11/2010) | | **5.0 - 7.5** | **165 - 170** | **629** | **654** | (7) | 0 |

* Nisreen Booya was in reciept of pension from 30/09/11 and so the CETV is nil.
** Terrence Dutchburn left 30/11/10 and is in reciept of pension and so the CETV is nil.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

.....Chief Executive.....Date

## Membership

The Trust works hard to promote the benefits of membership with local communities. We have a good track record and reputation for public involvement and firmly believe that working with our members will help secure the most effective and responsive NHS services for local people. We are determined to make the most of the opportunities that membership affords us to engage with people living in the communities we serve to make sure our services meet local need.

Eligibility for membership, as defined in our constitution, is that any individual who lives in Calderdale, Kirklees, Wakefield, and Yorkshire and the Humber may become or continue as a member of the Foundation Trust. Membership is restricted to those aged 11 years and older, and is not permitted for individuals who within the last five years have been involved as a perpetrator in a serious incident of violence at any of our hospitals or facilities or against any of our employees or other persons who exercise functions for the purposes of our organisation.

As at 31 March 2011, we had 11,147 public members and 2,597 staff members. This is broken down as follows.

| | |
|---|---|
| Calderdale | 2,024 |
| Kirklees | 5,009 |
| Wakefield | 3,030 |
| Yorkshire and the Humber | 1,084 |

Becoming a member of the Trust offers local people a unique opportunity to have their say and be involved in how the Trust and its services are developed. During 2010/11, the Trust's membership strategy was to maintain its level of membership at 1% of the population of Calderdale, Kirklees and Wakefield, to ensure that this membership is representative of the communities within these local authority areas, and to work towards an engaged and committed membership. The Trust measures it membership by ethnicity, gender, age and socio-economic group and recruitment is focused on areas of underrepresentation, which in 2010/11 has been males, young people aged between 11 and 14, older people over 85, and socio-economic group E. The Trust has a good track record of reflecting the ethnic diversity of the communities it serves in its membership.

Recruitment initiatives have included working with community and faith groups and developing an educational programme for young people linked to the health and social care curriculum, which will explain mental health issues and promote an anti-stigma message. This has been piloted in participating high schools during the year.

The Trust's Members' Council plays a role in determining the future membership strategy and agreeing necessary actions. A representative group from the Members' Council reviewed the membership strategy in December 2010, which was approved by the full Members' Council in January 2011.

The Strategy also sets out how the Trust evaluates the successful implementation of the strategy in terms of:

- regular measurement of activity against the targets set for membership and a focus on areas where membership is under-represented;
- benchmarking progress against other comparable Foundation Trusts;
- seeking feedback from members and Members' Council on communication methods and the clarity and timing of the information shared;
- monitoring the number of members participating in events, meetings and elections;

- ensuring the Members' Council reviews the strategy for membership and to ensure an on-going commitment to developing, maintaining, extending and communicating with an active membership of the Trust.

Performance against these criteria is reported to the membership by the Members' Council to the annual members' meeting.

Trust staff automatically become members of our Trust. As members, they can influence future plans, use their vote to elect a representative onto the Members' Council or stand for election themselves. Staff are encouraged to be actively involved as members of the Trust, to promote membership to friends and family, and to help reduce the stigma associated with mental health and learning disability issues. Staff membership is broken down as follows:

| | |
|---|---|
| Allied Health Professionals | 344 |
| Medicine and Pharmacy | 114 |
| Non-clinical support | 499 |
| Nursing | 880 |
| Nursing support | 604 |
| Psychological Therapies | 118 |
| Social care staff working in integrated teams | 38 |

When people join us as a member of the Trust, they have the option to choose the level of involvement that's right for them. This can be:

- receiving information about the Trust and its services through the Trust's member magazine, Like Minds, and voting in elections to the Members' Council;
- attending events and meetings that might be of interest;
- participating in specific projects;
- standing for election to the Members' Council.

The Trust held its first annual members' meeting in October 2010. This included a second service user artwork exhibition following the successful launch in the previous year. Members were also invited to join in a range of activities across the Trust in support of World Mental Health Day in October.

During the year the Trust introduced a series of educational insight events, which provides an opportunity for members to find out more about mental health problems. These events are led by the Trust's Medical Director and provide an opportunity to listen to an educational talk on a particular condition, followed by time for questions. The first of our events took place in November 2010 and we have future events planned right up until October 2011. The first four talks gave an insight into bipolar disorder (manic depression) and these will be followed by a series of talks to give an insight into dementia during 2011.

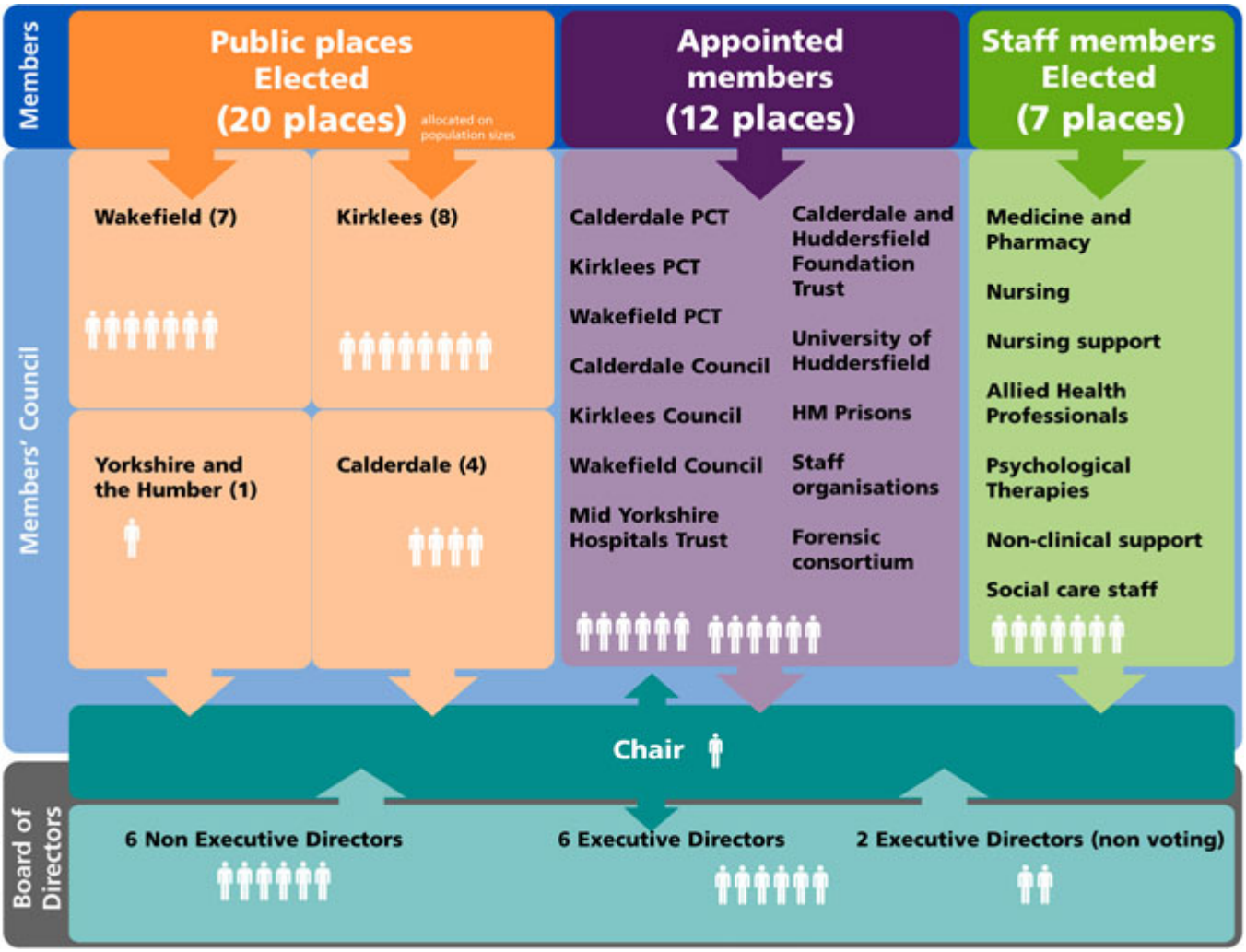
## Our Members' Council

The Members' Council's role is to make sure that Trust Board, which retains responsibility for the day to day running of the Trust, is accountable to the local community.

The Members' Council is made up of elected public representatives of members from Calderdale, Kirklees, Wakefield, and the wider Yorkshire and Humber area, elected staff representatives, and appointed members from key local partner organisations, for example primary care trusts and local authorities. It provides an important link between the Trust, local communities and key organisations, sharing information and views that can be used to develop and improve services. The Members' Council is chaired by the Chair of the Trust, who ensures appropriate links between the Members' Council and the Trust Board.

In April 2010, following a process agreed by the Members' Council, the Nominations Committee recommended the appointment of Irene Chaloner, publicly elected Council Member for Kirklees, as Lead Governor for the Members' Council. The role of the Lead Governor is to act as the communication channel for direct contact between Monitor and the Members' Council, should the need arise, to chair any parts of Members' Council meetings that cannot be chaired by the person presiding (i.e. the Chair or Deputy Chair of the Trust) due to a conflict of interest in relation to the business being discussed, to be a member of Nominations Committee (except when the appointment of the Lead Governor is being considered), to be involved in the assessment of the Chair and Non-Executive Directors' performance, and to be a member of the Development Group to assist in the planning and setting of the Members' Council agenda.

There are 39 places on the Members' Council in total (see below). Members were elected to take up their positions from May 2009 and around one third of positions come up for re-election each year.




| Name/representing | Term of office | Attendance during 2010/11 |
|---|---|---|
| **KRISHNAPILLAI, Thiruvenkatar**<br>Elected – public<br>Calderdale | 1 May 2009 for one year<br>Re-elected 1 May 2010 for one year | Attended none out of five meetings |
| **HORSFALL, Grenville**<br>Elected – public | 1 May 2010 for three years | Attended four out of five meetings |

| Name/representing | Term of office | Attendance during 2010/11 |
|---|---|---|
| Calderdale | | |
| **SMITH, Michael**<br>Elected – public<br>Calderdale | 1 May 2010 for three years | Attended three out of five meetings |
| **WILKINSON, Tony**<br>Elected – public<br>Calderdale | 1 May 2010 for three years | Attended five out of five meetings |
| **CHALONER, Irene**<br>Elected – public<br>Kirklees | 1 May 2009 for three years | Attended six out of six meetings |
| **GILL, David**<br>Elected – public<br>Kirklees | 1 May 2010 for three years | Attended three out of five meetings |
| **HERATY, Ian**<br>Elected – public<br>Kirklees | 1 May 2010 for three years | Attended two out of five meetings |
| **JOHN, Victor**<br>Elected – public<br>Kirklees | 1 May 2009 for two years | Attended three out of six meetings |
| **MORTIMER, Bob**<br>Elected – public<br>Kirklees | 1 May 2009 for three years | Attended four out of six meetings |
| **RIGBY, Dave**<br>Elected – public<br>Kirklees | 1 May 2009 for two years | Attended five out of six meetings |
| **SMITH, Jeremy**<br>Elected – public<br>Kirklees | 1 May 2009 for three years | Attended four out of six meetings |
| **WOODHEAD, David**<br>Elected – public<br>Kirklees | 1 May 2010 for three years | Attended three out of five meetings |
| **BROWN, Ann**<br>Elected – public<br>Wakefield | 1 May 2009 for two years | Attended three out of six meetings |
| **DALE, Doug**<br>Elected – public<br>Wakefield | 1 May 2009 for three years | Attended five out of six meetings |
| **KITCHEMAN, Steve**<br>Elected – public<br>Wakefield | 1 May 2009 for one year<br>Re-elected 1 May 2010 for three years | Attended four out of six meetings |
| **LOWE, Mary**<br>Elected – public<br>Wakefield | 1 May 2010 for three years | Attended three out of five meetings |
| **PLUMMER, Wendy**<br>Elected – public<br>Wakefield | 1 May 2009 for three years | Attended four out of six meetings |
| **TENNANT, Gordon**<br>Elected – public<br>Wakefield | 1 May 2010 for three years | Attended four out of five meetings |
| **WALKER, Peter**<br>Elected – public<br>Wakefield | 1 May 2010 for three years | Attended five out of five meetings |
| **BASU, Ranjan**<br>Elected – staff<br>Medicine and Pharmacy | 1 May 2009 for three years | Attended one out of six meetings |
| **BRADBURY, Jean**<br>Elected – staff<br>Social care staff in integrated teams | 1 May 2009 for three years | Attended one out of six meetings |
| **SPENCER, Julie**<br>Elected – staff<br>Non-clinical support staff | 1 May 2010 for three years | Attended three out of five meetings |
| **MERRILL, Tom**<br>Elected – staff<br>Nursing support | 1 May 2010 for three years | Attended one out of five meetings |
| **PLUMMER, Simon** | 1 May 2009 for three years | Attended four out of six |

| Name/representing | Term of office | Attendance during 2010/11 |
|---|---|---|
| Elected – staff<br>Allied Health Professionals | | meetings |
| **SMITH, George**<br>Elected – staff<br>Nursing | 1 May 2009 for three years | Attended three out of six meetings |
| **BENNETT, Inara**<br>Appointed<br>Staff side organisations | 1 May 2009 for three years | Attended five out of six meetings |
| **BRADSHAW, Angela**<br>Appointed<br>Calderdale and Huddersfield NHS Foundation Trust | 1 May 2009 for three years | Attended five out of six meetings |
| **BURNS, Mick**<br>Appointed<br>Secure Commissioning Consortium | 1 May 2009 for three years | Attended three out of six meetings |
| **CANNON, Sue**<br>Appointed<br>NHS Calderdale | 1 May 2009 for three years | Attended three out of six meetings |
| **TENNANT, Clive**<br>Appointed<br>Wakefield Metropolitan District Council | 25 June 2010 for three years | Attended one out of five meetings |
| **GRASBY, Roger**<br>Appointed<br>NHS Wakefield District | 1 May 2009 for three years | Attended three out of six meetings |
| **EMERY, Moya**<br>Appointed<br>Mid Yorkshire Hospitals NHS Trust | 28 July 2010 for three years | Attended one out of four meetings |
| **PADGETT, Kath**<br>Appointed<br>University of Huddersfield | 1 May 2009 for three years | Attended two out of six meetings |
| **REASON, Graham**<br>Appointed<br>Calderdale Metropolitan Borough Council | 1 May 2009 for three years | Attended two out of six meetings |
| **SMALL, Tracy**<br>Appointed<br>NHS Kirklees | 1 May 2009 for three years | Attended four out of six meetings |

The following Council Members left the Members' Council during 2010/11.

| Name/representing | Term of office ended/reason |
|---|---|
| **MELLOR, Beverley**<br>Elected – public<br>Calderdale | 28 April 2010<br>Resigned |
| **SNEE, Michael**<br>Elected – public<br>Calderdale | 30 April 2010<br>Not re-elected |
| **UZOMAH, Austine**<br>Elected – public<br>Kirklees | 30 April 2010<br>Did not stand for re-election |
| **SAWYER, Peter**<br>Elected – public<br>Yorkshire and Humber | 8 February 2011<br>Resigned |
| **FRAISE, Jon**<br>Elected – staff<br>Psychological Therapies | 25 August 2010<br>Retired from the Trust |
| **CUMMINGS, Maureen**<br>Appointed<br>Wakefield Metropolitan District Council | 25 June 2010<br>Resigned |
| **JENKINS, Richard**<br>Appointed<br>Mid Yorkshire Hospitals NHS Trust | 24 May 2010<br>Resigned |

Interests declared by Council Members can be found on the Trust's website at http://www.southwestyorkshire.nhs.uk/about-us/members-council/register-of-interests/

Nominations for election to the Members' Council were sought in early 2010 for terms of office beginning 1 May 2010 as follows:

- Calderdale – two seats;
- Kirklees – three seats;
- Wakefield – four seats;
- Yorkshire and Humber – one seat;
- Non-clinical support staff – one seat;
- Nursing support – one seat.

Elections were held during the spring of 2010 for two seats in Calderdale, for four seats in Wakefield and for one seat for non-clinical support staff. The seats in Kirklees, Yorkshire and the Humber, and Nursing Support were uncontested.

At each meeting of the Members Council, the Chair and Chief Executive present an overview of the key issues arising from Trust Board meetings together with a strategic overview of national, regional and local developments and the potential impact on the Trust, followed by a number of round table discussions on key areas.

A joint meeting is held annually between Trust Board and the Members Council. At the meeting in January 2011, the national context and its implications and challenges in developing the Trusts plans for 2011/12 and beyond were set out and the challenges to both commissioners and providers discussed, covering the role of GP commissioners, the enhanced role of local authorities in public health including the establishment of Health and Wellbeing Boards, the establishment of the NHS Commissioning Board and the changing role of Monitor to that of economic regulator. The future emphasis for Foundation Trusts will be on self-certification, sustainability and viability and the Members Council and our membership will strengthen local accountability.

The joint meeting with Trust Board reviewed and re-confirmed the Trust's strategic objectives and workshops covered the following areas linked to the Trust's strategic objectives led by Executive Directors and supported by Non-Executive Directors.

- Service offer and link to service line management – clarification and development of the pathways needed to support the delivery of effective services going forward, whilst ensuring that the Trust devolves control from a management and leadership perspective to best effect to BDUs to deliver optimum business outputs and productivity.
- Quality – ensuring the Trust delivers maximum value for money, delivers continuous improvement in the quality of its services and supports innovation through the development of the Quality Academy approach.
- Ensuring the Trust continues to be viable and sustainable – examination of the risks facing the Trust.
- Partnerships – ensuring the Trust maximises the benefit of its existing partnerships and develop the partnerships it will need in the future, most notably with GPs.

The outputs from the workshops with the Members Council have informed and contributed to development of the Trust's annual plan for 2011/12, in particular:

- the impact of new services acquired through TCS on new service offer and shift to person-centred provision, focus on service user experience and development of person centred offer;

- the identification of what is important to service users, namely access to services, pathway access and referrals, support for carers, care and care planning;
- managing risks through relationships with partners.

During the year the Members' Council was involved in a number of other projects, including the following.

Strategy and forward plans
- Briefing on service delivery in preparation for the joint meeting with Trust Board in January 2011.
- Strategic direction and the challenges facing Trust moving forward beyond 2009/10.
- Developing Quality Accounts
- Forward plan for 2011/12 (joint meeting with Trust Board) in January 2011.
- Development of the Trust's involvement strategy.
- Preparation for the Annual Members' Meeting and attendance.
- Reviewing the Trust's values.
- Developing the Trust's approach to valuing people's contribution.
- Developing the Membership Strategy.
- Developing the Trust's approach to measuring the patient experience.
- Reviewing and developing the budget for the Members' Council.

Statutory duties
- Appointment of external auditor.
- Appointment of Non-Executive Directors.
- Pre-election workshops.

Trust activity
- Listening and visioning events.
- St. Luke's project board.
- Involvement in judging for Excellence 2010.
- Appointment of Director of Corporate Development and District Directors.
- Sustainability champions events.

Four Working Groups were set up in on authorisation in May 2009 to look at community engagement, tackling stigma, engagement of young people and Members' Council development. The Members' Council took the decision during 2010/11 to formalise its sub-group arrangements and now has four.

- The Nominations Committee is responsible for overseeing the process to appoint the Chair, Non-Executive Directors, Deputy Chair/Senior Independent Director and Lead Governor.
- The Co-ordination Group co-ordinates the work and development of the Members' Council.
- A third group focuses on the Membership Strategy and incorporates communications and engagement with members and the wider public.
- The last group works with the Trust to review and develop its Quality Accounts.

## Nominations Committee

The Nominations Committee's prime purpose is two-fold. Firstly, to ensure the right composition and balance of the Board and, secondly, to oversee the process for the identification, nomination and appointment the Chair and Non-Executive Directors of the Trust, to oversee the process for the identification, nomination and appointment of the Deputy Chair and Senior Independent Director of the Board, and to oversee the process to identify, nominate and appoint the Lead Governor of the Members' Council.

| | |
|---|---|
| Joyce Catterick, Chair of the Trust (Chair) | Attended three out of three meetings |
| Steven Michael, Chief Executive | Attended three out of three meetings |
| Angela Bradshaw, Members' Council (appointed – Calderdale and Huddersfield NHS Foundation Trust) | Attended two out of three meetings |
| Irene Chaloner, Members' Council (publicly elected – Kirklees) and Lead Governor (member for March meeting only) | Attended one out of one meeting |
| Steve Kitcheman, Members' Council (publicly elected – Wakefield) and representing service users' interests (member for December and March meetings) | Attended two out of two meetings |
| Thiruvenkatar Krishnapillai, Members' Council (publicly elected – Calderdale) | Attended two out of three meetings |
| Beverley Mellor, Members' Council (publicly elected – Calderdale) and representing service users' interests (member for April meeting only) | Attended one out of one meeting |

The Nominations Committee works in accordance with the Trust's Constitution, with the Members' Council appointing Non-executive Directors using the following procedure.

- The Nominations Committee, on behalf of the Members' Council, maintains an approach to the composition of the Non-Executive Directors, which takes account of the membership strategy, and which is reviewed regularly and not less than every three years.
- As appropriate, the Nominations Committee works with external organisations recognised as experts at appointments to identify candidates with appropriate skills and experience required for Non-Executive Directors vacancies.
- Appropriate candidates are identified by the Nominations Committee through a process of open competition, which takes account of the above approach and the skills and experience required.
- The Nominations Committee is made up of the Chair of the Trust (or, when a Chair is being appointed, another Non-Executive Director), the Chief Executive, a minimum of two Council Members selected by the Members' Council (currently three), and the Lead Governor. The Nominations Committee has the power to co-opt external persons to act as independent assessors to the Nominations Committee.

During 2010/11, The Nominations Committee has appointed one Non-Executive Director (Jonathan Jones from 1 June 2010) to fill one of two vacancies that arose in May 2010 due to the terms of office of two Non-Executive Directors coming to an end. This process was overseen by the Nominations Committee, which agreed the skills and experience the Trust Board required at the time and appointed the Appointments Commission to manage the process on behalf of the Trust.

During the year, the terms of reference for the Committee changed following agreement by the Members' Council that appointment of the Lead Governor and appointment of the Deputy Chair/Senior Independent Director should be within the role of the Nominations Committee. The Lead Governor (Irene Chaloner) was appointed by the Nominations Committee (and ratified by the Members' Council) from 1 May 2010, and the Deputy Chair/Senior Independent Director (Ian Black) was appointed by the Nominations Committee (and ratified by the Members' Council) from 1 June 2010.

# Operating and Financial Review

**Quality Review**

Quality of service delivery is central to all we do. Trusts are required to produce quality accounts to evidence the quality of services and plans to maintain and improve current standards. These are detailed accounts of performance against a range of targets, which are made available to the public through the NHS Choices website, and are also used by commissioners and regulators.

The Trust's Quality Accounts for 2010/11 are incorporated into this report. Further information on quality governance and quality is also included in the Annual Governance Statement.

For 2010/11, our clinical quality priorities were:

- mutual respect between service users and staff (understanding what people who use services feel about their treatment, and using complaints and survey results to identify areas for improved performance);
- personalised care (ensuring service users are fully engaged in care planning);
- improving practice and positive outcomes for service users (responding to national regulator findings and compliance with national standards);
- improving environment and hotel services (offering care in surroundings that promote wellbeing, encompassing the national priorities such as the elimination of mixed sex accommodation and effective infection control);
- suicide prevention and risk management (compliance with safeguarding procedures and individual clinical risk assessment).

To meet these priorities, the Trust has implemented a quality plan, the key aspects being:

- development of a Quality Academy to bring support services together and revise their "offer" to Business Delivery Units, ensuring that all services are focussed on adding value to the people who are in our care impacting on improving practice and positive outcomes;
- implementation of the Productive Mental Health Ward has led to inpatient facilities focussing on how they can release time to care by reducing activities that do not add value to patient care;
- further developing the Care Programme Approach (CPA) and implementing the CPA strategy so that people receive personalised care plans that impact on them achieving positive outcomes;
- reviewing the environment and reducing risk by moving services off St Luke's Hospital site to more appropriate accommodation in the Kirklees and Calderdale areas;
- implementing real-time patient feedback kiosks in in-patient wards so that service changes can be made to support improved patient experience;
- developing an incident review committee to support learning from serious incidents in order to implement change to prevent further incidents occurring.

During the year, Trust Board approved the Quality Improvement strategy, which sets out the Trust's approach to Quality Improvement. Quality improvement is seen within the Trust as a fundamental element of everybody's day-to-day work. A key part of the Strategy is the Quality Academy approach, developed as the infrastructure to support teams and individuals in developing skills, experience and leadership in quality improvement. The Quality Academy provides support, leadership, tools and services to all parts of the organisation to enable us to:

- provide high quality services to our service users;
- develop and innovate;
- meet our regulatory requirements.

Our Quality Academy approach supports front line staff and managers in four ways through:

- routine support, ensuring good quality service delivery;
- support to ensure compliance with our regulatory bodies and performance targets;
- tools and facilitation to support improvement and innovation;
- horizon scanning to know what's new and consider how we respond.

Looking forward, the Clinical Governance and Clinical Safety Committee has tasked the Trust with evaluating its compliance with Monitor's Quality Governance Framework and the outcome of this piece of work will report early in 2011/12.

The Trust can also confirm there are no inconsistencies between the Annual Governance Statement, self-certifications made to Monitor and Care Quality Commission reports.

**Performance review and analysis of key performance indicators**

Trust Board identified a number of key performance indicators for 2010/11, which relate to key areas of Trust activity. More detailed information on the Trust's performance against national, local and Monitor targets can be found in the Quality Accounts. The following is a summary of the position at 31 March 2011.

| Business Strategic Performance – impact and delivery | | | |
|---|---|---|---|
| | **KPI** | **Target** | **Month 12 position** |
| **Monitor Compliance** | Monitor Governance risk rating (FT) | Green | Green |
| | Monitor Finance risk rating (FT) | 3.5 | 4.1 |
| **CQC** | CQC quality regulations (compliance breach) | 0 | 0 |
| **CQUIN** | Regional CQUIN | Green | Green |
| | Local CQUIN Calderdale | Green | Green |
| | Local CQUIN Kirklees | Green | Green |
| | Local CQUIN Wakefield | Green | Green |
| | Forensic CQUIN | Green | Green |
| | WMDC CQUIN | Green | Green |
| | % SU assessed within 4 hours of referral (CRS) | >60% | 73.5% |
| | % SU assessed within 14 days (adults) | > = 60% | 70.4% |
| **IAPT** | Total number of people seen in IAPT | 4013 | 4361 |
| | Total number of people supported back into employment | > = 62 | 116 |
| | Infection prevention | 0 | 0 |
| | Eliminating mixed sex accommodation | 95% | 95% |

| Customer focus | | | |
|---|---|---|---|
| | **KPI** | **Target** | **Month 12 position** |
| **Complaints** | % complaints with staff attitude as an issue | <30% | 14% |
| **MAV** | Physical violence – against patient by patient | Green | Green |
| | Physical violence – against staff by patient | Green | Green |
| **Equality** | % of policies, strategies, services and functions subject to EIA | 100% | 100% |
| **FOI** | % of requests for information under the act processed in 20 working days | 100% | 100% |
| **Media** | % of positive media coverage relating to the Trust and its services | >60% | 77% |
| **Members' Council** | % of publicly elected council members actively engaged in Trust activity | >50% | 80% |
| | % of quorate council meetings | 100% | 100% |
| | % of vacancies carried by the Members' Council | <10% | 7.7% |
| **Membership** | % of population served recruited as members of the Trust | 1% | 1.1% |
| | % of 'active' members engaged in Trust initiatives | >50% | 35% |
| **Befriending services** | % of service users allocated befriender within 16 weeks | >75% | 50% |
| | % of service users requesting a befriender assessed within 20 working days | >80% | 100% |
| | % of potential volunteer befriender applications processed within in 20 working days | >90% | 100% |

| | | | |
|---|---|---|---|
| | Service user experience (% position feedback) | >50% | 88.6% |

| Operational effectiveness; process effectiveness | | | |
|---|---|---|---|
| | **KPI** | **Target** | **Month 12 position** |
| **Quality** | NICE guidance implementation | 4 criteria | Green |
| | Number of all incidents involving restraint | | 281 |
| | Number of unique SU subject to seclusion | | 28 |
| | Number of incidents of AWOL (detained patients) | 54 | 45 |
| **Inpatients** | Delayed transfers of care | < = 7.5% | 4.8% |
| | % admissions gatekept by CRS teams (Monitor) | 90% | 93% |
| **Community** | % SU on CPA offered a care plan (AWA &OPS) | > = 80% | 81.9% |
| | % SU on CPA followed up within 7 days of a discharge (Monitor) | 95% | 96.1% |
| | % SU on CPA having formal review within 12 months (Monitor) | 95% | 97.5% |
| | EIP Service – new cases (PCT) (Monitor) | 95% | 213% |
| **Data quality** | % inpatients (CPA) discharged with valid diagnosis code | 85% | 67.6% |
| | Monitor data quality: identifiers | 99% | 98.6% |
| | Monitor data quality: outcomes | 50% | 75.9% |
| | % CPA clients with HoNOS in last 12 months (Monitor) | 50% | 52.3% |
| **Finance** | Delivery of CIPs | £4.8m | £4.7m |
| | Cash position | £12.6m | £18.2m |
| | In month better payment practice code | 95% | 98% |

| Fit for the future: workforce | | | |
|---|---|---|---|
| | **KPI** | **Target** | **Month 12 position** |
| **Appraisal** | % of staff who have had an appraisal in the last 12 months | > = 80% | 81.5% |
| **Sickness** | Sickness absence rate | < = 4.5% | 5.4% |
| **Vacancy** | Vacancy rate | <10% | 7% |

NB Where an area of Trust performance is covered by a number of KPIs, the overall rating of green, amber or red is based on the weighting applied to each component part.

Action plans are in place to address underperformance on data quality and sickness absence.

## Our staff

Trust staff are our largest and most important resource. It is their innovative practice, professionalism and dedication which enables us to make a difference to the lives of people who need to use our services, and those who care for them.

We try to create an environment to work in which makes our staff, both as part of a team and as individuals, feel supported and empowered to make a difference to the way we provide services for local people. This means we need a diverse workforce that is skilled, motivated and competent so we are able to continue providing responsive, effective and safe mental health and learning disability services.

The table below shows the staff in post by the different occupation groups as at 31 March 2011.

| **Staff in post by occupation group** | **2010/11** |
|---|---|
| Professional, scientific and technical | 149 |
| Additional clinical services | 590 |
| Administration and clerical | 459 |
| Allied health professions | 122 |
| Estates and ancillary | 195 |
| Medical | 122 |
| Nursing | 907 |
| Students | 10 |
| Total | 2554 |

| Equality and diversity | Staff as at 31.03.11 |
|---|---|
| Age | Nos. |
| 16 – 20 | 8 |
| 21 – 25 | 151 |
| 26 – 30 | 213 |
| 31 – 35 | 279 |
| 36 – 40 | 321 |
| 41 – 45 | 375 |
| 46 – 50 | 466 |
| 51 – 55 | 356 |
| 56 – 60 | 238 |
| 61 – 65 | 101 |
| 66 – 70 | 19 |
| 71+ | 7 |
| Ethnicity | % |
| White | 92.56 |
| Mixed | 1.11 |
| Asian or Asian British | 2.69 |
| Black or Black British | 3.01 |
| Other | 0.63 |
| Gender | Nos. |
| Male | 662 |
| Female | 1872 |

The staff turnover rate for the Trust for 2010/11 was 7.9%, within the target range of 10%. Trust Board set a target sickness absence rate of 4.5% for 2010/11; the end of year rate was 5.4%. Although the Trust did not meet its target it achieved the lowest sickness absence levels for mental health trusts in Yorkshire and the Humber in the last year.

We are committed to regular communication and engagement with our staff on all matters of concern to them as employees, including matters relating to Trust performance and the financial and economic factors that affect this. We regularly look for ways to enhance that dialogue. We promote regular team meetings, informal monthly sessions with the chief executive in all localities, weekly email bulletins, bi-monthly newsletters dedicated to issues that impact on staff and feature broad ranging and up to date information on our intranet.

The main vehicle for discussions between management and staff representatives is the Trust-wide Social Partnership Forum which meets monthly. All major change management initiatives are discussed in this arena, and there is robust and constructive dialogue and challenge. There are locality consultative meetings also, which look in more detail at local issues. Staff representatives on the Trust's Members' Council also play their part in engaging with staff in their constituent groups.

The Trust worked on a number of initiatives to support staff in the last year, including the following.

- The Trust achieved Investors in People (IiP) accreditation in June 2009. IiP is a highly prestigious and much sought-after national standard of good employment practice and organisational improvement. During 2010/11, the Trust continued to work with the Standard and will be seeking recognition to the gold level of accreditation in 2011/12.
- The Trust held its annual celebration of positive practice event, 'Excellence 10' in November 2010. The event included a showcase of innovative practice to promote shared learning and an award ceremony. There were over 100 entries into the awards scheme from across all services and geographical localities. Judges included service users and carers, Trust staff (from clinical and non-clinical services), Members' Council

representatives, non-executive directors and external partners from our local health economy.

- The Trust continued to promote and support leadership training and development. The Trust delivered a two-day middle management training programme to over 400 managers in conjunction with Robertson Cooper Occupational Psychologists. The programme was designed to support continued development of organisational, team and individual resilience. Participants completed and received feedback on two personality questionnaires concerning individual resilience and also their leadership impact style.
- The Trust has also worked in conjunction with Right Management to deliver a development programme for heads of service and General Managers to support the new Business Delivery Unit organisational structure.
- The Trust recognises that staff wellbeing is a critical factor in motivation and the ability to deliver a quality service. A 'Well-being at Work' Partnership Group has been established involving senior managers and staff side representatives to develop the well-being agenda. A 'Creating well-being in employment' action plan has been agreed. There has been further investment in the staff retreat and also the development of an Occupational Health Physiotherapy pilot offering fast track physiotherapy service for staff.
- The Trust has recently reviewed the effectiveness of its local partnership arrangements with staff side colleagues and feedback has been positive.
- During the year, the Trust has implemented an e-rostering system across all in-patient areas and has developed a Trust-wide staff bank, which has significantly reduced reliance on overtime and agency usage.

**Staff survey**

The annual national staff survey, which aims to improve the working experience in the NHS, was carried out in October 2010. The survey was sent to a randomly selected sample of 800 Trust staff. The response rate was 53%, the same rate as in 2009, and was in line with the national average for mental health trusts. The overall level of staff engagement within the Trust is above average.

The survey results are presented across 40 key findings. The Trust's results were in the best 20% for mental health and learning disability services for the following key findings:

- work pressure;
- staff intention to leave their job;
- staff reporting errors/near misses;
- staff feeling pressure in last three months to attend work when not well;
- staff experiencing work related stress.

| | 2009/10 | | 2010/11 | | Trust position |
|---|---|---|---|---|---|
| Response rate | **Trust** | **National average** | **Trust** | **National Average** | |
| | 53% | 55% | 54% | 54% | Average |

| | 2009/10 | | 2010/11 | | Trust position |
|---|---|---|---|---|---|
| **Top four ranking scores** | **Trust** | **National average** | **Trust** | **National Average** | |
| Work pressure | 2.92% | 3.02% | 2.80% | 3.01% | Best 20% |
| Staff intention to leave their job | 2.4% | 2.58% | 2.36% | 2.55% | Best 20% |
| Staff reporting errors/near misses | 97% | 97% | 99% | 97% | Best 20% |
| Staff receiving training, job related learning and development in the last 12 months | 85% | 81% | 83% | 80% | Best 20% |

There were three key findings where the Trust was in the worst 20%:

- support from immediate managers;
- staff receiving equality and diversity training;
- staff experiencing harassment/bullying from colleagues.

| | 2009/10 | | 2010/11 | | Trust position |
|---|---|---|---|---|---|
| **Top four ranking scores** | **Trust** | **National average** | **Trust** | **National Average** | |
| Support from immediate managers | 3.81% | 3.78% | 3.73% | 3.8% | Worst 20% |
| Staff receiving equality and diversity training | 33% | 42% | 36% | 47% | Worst 20% |
| Staff experiencing harassment/bullying from colleagues | Changed format of question i.e. no comparison with 2009 | | 16% | 14% | Worst 20% |
| Impact of health and well-being on ability to carry out work or daily activities | 1.66% | 1.62% | 1.65% | 1.62% | Worse than average |

The Trust improved on the following findings in comparison to the previous year's results:

- staff receiving appraisal;
- staff receiving well-structured appraisals;
- staff receiving appraisal and personal development plans.

The Trust results have worsened in the following areas since the 2009 survey results:

- Trust commitment to work-life balance;
- support from immediate managers.

Work is underway to develop an action plan to address those issues raised by the survey results. The action plan will focus on expanding the types of equality and diversity training and making it mandatory for all staff, encouraging support to staff from immediate managers through the implementation of the Investors in People Standard, ensuring all staff are able to constructively challenge any perceived harassment and bullying, and continued development of the well-being at work agenda. The 'Well-being at Work Partnership Group' will agree the action plan and monitor progress.

The key workforce priorities for the coming year include the following.

- Delivery of an organisational development plan following the transfer of staff under Transforming Community Services.
- Review of the Trust's workforce plan to support delivery of new service plans and the long term financial model.
- Continued delivery of the wellbeing and engagement plan including reducing levels of sickness absence and a follow up wellbeing survey in 2011.
- Reducing management and administration expenditure as part of the workforce Quality Innovation Productivity and Prevention plan.
- Further implementation of the Investors in People Standard with the aim of achieving gold level accreditation.
- Introducing an E-HR system to support managers in undertaking their role and ensuring all HR processes incorporate lean thinking.
- Review of all key employment policies and procedures

Performance against these priorities will be monitored by the Trust Board and Executive Management Team through a quarterly HR Performance Report.

## Sustainability report

The Trust is committed to being a socially responsible organisation. In the broadest of terms, this includes introducing measures that reduce or offset our environmental impact. We are committed as an organisation to understanding, managing and reducing our carbon footprint in response to:

- the legally binding Government framework and national targets;
- the health benefits for people who use our services, for local populations, and for the health system itself;
- the importance of being a good corporate citizen;
- the importance of cost reductions and energy resilience becoming a low carbon trust;
- the need for the NHS to be a leading public sector exemplar;
- the scientific evidence to act now on climate change.

Trust Board approved the Sustainability Strategy and high level actions in June 2011, which have a focus on the following key areas:

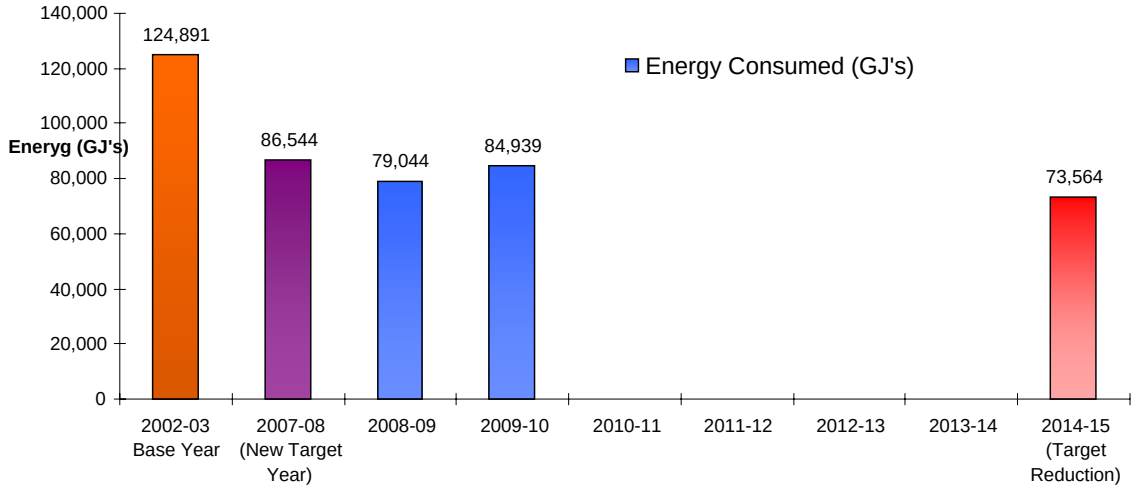
- using our resources to best effect;
- making the best use of available technology;
- being a good Corporate Citizen;
- procuring goods and services in a sustainable manner;
- making a financial saving of £210,000 in 2011/12.

Progress in these four areas in 2010/11 includes the following.

1. As part of our ongoing plans to reduce our carbon footprint, reduce and optimise resources we have joined the Carbon Trust' NHS Carbon Management Programme; this project will support the process of setting energy efficiency and carbon reduction targets for the next one, three, five, and ten years.
2. Agreeing a project with the Energy Saving Trust (EST) to carryout a Green Fleet Review with the aim of producing recommendations to reduce our fleet vehicle costs, reduce carbon emissions, reduce our environmental impact and help increase our commitment to corporate social responsibility.
3. Developing a municipal/recycling waste contract to be awarded this summer which covers recycling of glass, tins/cans, paper, cardboard, batteries and plastics with an explicit intention to work with the successful contractor towards a zero landfill regime for Trust waste.
4. Further expanding the use of teleconferencing facilities to reduce travel and travel time.
5. Working in partnership with Canon UK to implement a document management system which will look at the rationalisation of desk top printers and replace them with fewer multi-functional devices. The potential benefits include reduced costs, carbon emissions and wastage.
6. Creation of a directory of community venues for meetings and events for use when an external venue is required.
7. Roll out of a publicity campaign which raised awareness across the Trust which has included developing a network of over 60 'champions'.
8. Creation of a 'car sharing' database.
9. Commenced process of tendering of our general and domestic waste contract which will look to address such issues as; identifying current waste streams, implementing a waste management system and recycling.

10. Implementation of a Trust-wide initiative of only purchasing re-manufactured toner cartridges (where available) which will not only have an environmental impact but also a cost saving of approximately 30% on current toner cartridge expenditure.
11. Production of a Supplier *Code of Conduct* which forms part of all our tender documents and the terms of offer - also requests a response from those who tender in respect of the *Good Corporate Citizen* standards and their organisations position in terms of sustainability all of which is taken into consideration during the tender evaluation.
12. Launch of a sustainable procurement strategy and guide for our staff.
13. The Trust's Carbon Reduction Strategy covers the period 2008 to 2015, and concentrates on specific areas with a total target carbon saving of 1,006 Tonnes carbon CO2. We have reduced energy usage by over 28.80% over the last seven years; equivalent to 2596.62 tonnes of carbon. We are currently working to reduce energy by 15% reflecting anticipated estates rationalisation and building and plant improvements.

**Carbon Reduction Strategy 2008-2015**




**Target Reduction 12,980 GJs by 2015 (15%)**
**Actual 1,605 GJs 2008-10 (1.85%)**

Performance is reported to the Trust Board twice a year against the high level targets and KPIs and to the Executive Team monthly. The detailed progress of the work is monitored through the Sustainability Project Team and through the four action plans which have identified leads, targets and timescales.

| Area | Type | Non-Financial and financial Information |
|---|---|---|
| Greenhouse Gas Emissions | Scope 1 (Direct) GHG Emissions | The Carbon Reduction Commitment-Energy Efficiency Scheme (CRC-EES) is due to be re-launched in April 2011. There is a threshold set for organisations to whom the CRC-EES applies to, based on a total electricity consumption of 6,000 MWh/year for the 2008 baseline year. The total electricity consumed at Fieldhead and Castleford Hospitals was 3,320 MWh in 2008. As a result the Trust is only required to register an Information Disclosure having fallen below the threshold and is not required to participate in the full scheme CRC-EES. However, depending on the lease arrangements in respect of the transfer of CSD provider arm of NHS Barnsley from 1 May 2011 this could result in the threshold been exceeded and therefore, full participation will be required.<br><br>Based on the present position the Trust has only had to make an Information Disclosure, therefore, the total cost of participation has not been calculated. However, as it is calculated on Carbon Emissions it is expected to be in the region of £150,000 to £200,000 (based on £12/Tonne). |

<table>
<tr><th>Area</th><th>Type</th><th>Non-Financial and financial Information</th></tr>
<tr><td></td><td>Scope 2 (Energy Indirect) Emissions</td><td>Energy Consumption 2009/10<br>Fossil Fuel……84,030 GJ's<br>Electricity……21,635 GJ's<br><br>Source 2009-10 ERIC Returns<br><br>NB figures for 2010/11 will not be available until end of June 2011.</td></tr>
<tr><td></td><td>Scope 3 Official Business Travel Emissions.</td><td>Transport Mileage 2009/10<br>Business Mileage……3,024,564<br>Patient transport Mileage……133,400<br><br>Source 2009-10 ERIC Returns<br><br>The Trust is working with the Energy Saving Trust to translate business travel mileage to emissions but this information is not currently available</td></tr>
</table>

<table>
<tr><td>Waste minimisation and management</td><td>Waste Arising 2009/10<br><br>
<table>
<tr><th>Waste</th><th>09-10</th><th>09-10</th><th></th></tr>
<tr><td>Clinical waste Volume (Tonnes)</td><td>103.89</td><td>£67,968</td><td>incinerated</td></tr>
<tr><td>Domestic waste volume (Tonnes)</td><td>582.92</td><td>£87,326</td><td>landfill</td></tr>
<tr><td>Hazardous waste volume & WEEE (Tonnes)</td><td>5</td><td>£3,100</td><td>Mix of incineration. landfill and recycling</td></tr>
<tr><td>Total</td><td>691.81</td><td>£160,394</td><td></td></tr>
</table>
Source 2009-10 ERIC Returns<br><br>NB figures for 2010/11 will not be available until end of June 2011.</td></tr>
<tr><td>Finite Resources</td><td>Water Consumption 2009/10<br>50,321m3<br><br>Source 2009-10 ERIC Returns<br><br>The Trust does not require a licence as water is not extracted from a bore hole or river. Work is ongoing to agree our approach to the use of finite resources.</td></tr>
</table>

# Financial Position

**Introduction**
The Trust was authorised as a Foundation Trust on 1 May 2009; therefore, this is the first full year reporting as a Foundation Trust. This report and the accounts have been prepared in line with appropriate guidance including the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

**Overview of Financial Performance**
The Trust had an annual turnover of £128.3m for 2010/11 and an overall surplus of £3.3m for the year. Of the total income, 75% is generated by healthcare contracts with local PCTs (NHS Calderdale, NHS Kirklees and NHS Wakefield District) and Wakefield Metropolitan District Council and about 19% related to contracts for secure services commissioned by the Specialist Regional Commissioner. The majority of contract income is commissioned as a fixed payment. In 2010/11, 1.5% (£1.9m) of the income was dependent on achievement of quality targets set by commissioners. The Trust achieved all its performance related income in 2010/11 with the exception of £45k linked to two indicators where performance was less than the required target trajectory.

The Trust achieved a recurrent savings target of £4.8m during the year which represents a 4% efficiency target achievement.

Capital expenditure totalling £5.8m was incurred in the period. The Trust held a cash balance of £18.2m at 31 March 2011; this is an increase of £1.9m on March 2010. The high cash balance has been generated over a number of years to fund capital expenditure in future years. The capital commitment for the next five years is £39m, which will be funded from internally generated cash resources.

The Trust achieved the Better Payment Practice Code for NHS Trusts by paying over 98% of valid invoices within 30 days and complied with the principles of the CBI Prompt Payment Code by paying 92% of local suppliers within ten days.

| Income & Expenditure Performance for 2010/11 | | |
|---|---|---|
| | 2009/10 | 2010/11 |
| | Full Year | Full Year |
| | £k | £k |
| Income from Activities | 117,003 | 120,738 |
| Other Operating Income | 6,841 | 7,609 |
| Total Income | 123,844 | 128,347 |
| LESS | | |
| Operating Expenses | 116,601 | 123,680 |
| Interest Received | 90 | 194 |
| Public Dividend | 1,741 | 1,535 |
| Asset Impairment | 4,037 | 0 |
| Surplus | 1,555 | 3,326 |

The Trust was rated GREEN by Monitor in terms of its Governance and Mandatory Services Risk Ratings throughout 2010/11. In addition the organisation's financial position as assessed by Monitor using the Financial Risk Rating scored between 3.8 and 4.3 out of 5 during the period. The full year performance was better than plan due to the higher surplus achieved. This was in part due to early delivery of 2011/12 cost savings in 2010/11.

The Financial Risk Rating considers a number of key financial performance measures to assess the financial viability of a foundation trust such has having sufficient cash to meet outgoings and expenditure being in line with what was planned. The table shows the actual position for 2010/11compared to the plan submitted to Monitor in May 2010.

| Financial Risk Rating FY 2010/11 | | | | |
|---|---|---|---|---|
| | March 2011 Outturn Actuals | | May 2010 Plan | |
| Metric | Score | Rating | Score | Rating |
| EBITDA margin | 5.40% | 3 | 4.40% | 2 |
| EBITDA, % achieved | 125.30% | 5 | 99.90% | 4 |
| ROA | 8.30% | 5 | 6.30% | 5 |
| I&E surplus margin | 2.70% | 4 | 1.70% | 3 |
| Liquid ratio | 51.3 | 4 | 40.8 | 4 |
| Weighted Average | | 4.1 | | 3.5 |

**Capital Investment**

The Trust's financial plans include proposed expenditure on capital assets. Resources to spend on capital investments are generated internally from depreciation or surpluses or externally from borrowing. The Trust has financed its capital expenditure from internally generated resources. Capital resources are allocated and approved by Trust Board in support of the Integrated Business Plan. In-year monitoring of capital schemes is undertaken by the Estates Trust-wide Action Group and the Executive Management Team to ensure efficient and effective use of these resources.

**Treasury Management**

As a Foundation Trust the organisation is able to generate income by investing cash. During 2010, the Audit Committee reviewed the Treasury Management Policy. This policy takes a prudent approach as it is designed to maximize the interest received but permits investment in only the highest rated organisations to minimize the risk of losses. The Trust manages its working capital balances making payments on due dates in line with the NHS better payment practice code. Interest rates during 2010/11 have been relatively low. The Trust planned for £100k interest receivable for the year but managed to achieve £194k overall.

The Trust's cash balance was sufficient to meet its operational and capital outgoings throughout the financial year.

The Trust has a working capital facility, effectively an overdraft arrangement, with a commercial bank which would allow drawdown of £9.2m should the Trust at any time require cash to meet its obligations. The long term financial plan indicates the Trust has sufficient cash to fund all its outgoings without using this facility. The facility was not used during the financial year.

**International Financial Reporting Standards – IFRS**

The Trust aligned its financial reporting and accounting policies to meet International Reporting Standards in 2009/10. This revision makes the NHS reporting requirements consistent with the private sector. As part of its annual work programme the Audit Committee has reviewed the accounting policies applicable in 2010/11. There are no significant changes to accounting policies in 2010/11 and there are no material financial impacts on the 2010/11 accounts as a consequence of the application of accounting policies.

**Impact of IFRS Valuation of Assets**
The introduction of IFRS had a major impact on the Trust in 2009/10 which resulted in £4.1m reduction in value which was recognised as an impairment in 2009/10 (see table above). As part of the review of accounting policies the valuation of the assets on the balance sheet was reviewed and there were no material adjustments required in the accounts for 2010/11.

**Recording of Investment Property**
Estate which the Trust Board has declared surplus to requirements is recorded as investment property under IFRS and its value is updated annually to the current market value. The Trust has two small assets held as investment property with a combined value of £280k at March 2011. Any change in the valuation of investment assets in year is recognised in the income and expenditure account during the year. Investment properties increased in value by £10k for 2010/11.

**Holiday Pay Accrual**
The Trust accrual for holiday pay has increased by £208k in 2010/11. The implementation of the electronic rostering system during 2010/11 has enabled better recording of annual leave and has resulted in more data being available to calculate the leave outstanding.

**Key Financial Risks for the Future**
The key financial risks for the Trust going forward are:

- the impact of reduced levels of funding for public sector services caused by the economic downturn both in health and social care;
- the uncertainty in relation to commissioning intentions in future as GP consortiums develop and the development of the “any willing provider model”;
- ensuring that the PCT community services acquired through the Transforming Community Services Programme in 2011/12 (£96m) are integrated and contribute to the service and financial sustainability of the organisation;
- data quality and clinical systems are robust in the future to support service funding through tariff and evidence of outcomes;

As part of the preparation to meet the challenges of delivering “more for less”, the Trust in its business case for PCT community services and its Annual Plan has developed a series of downside scenarios. The scenarios model the impact of changes to the Trust’s income and expenditure and test whether the planned mitigation is sufficient to maintain financial viability. These have been reviewed by our economic regulator Monitor and rated Green.

The Trust continues to working in partnership key stakeholders including PCTs, emerging commissioning consortia and local authorities to develop joint approach to delivering improved quality, innovation, productivity in services and prevention of ill health and best use of resources in a period of significant economic challenge.

The Trust has a robust financial plan in support of its Integrated Business Plan. The plan is dependent upon the Trust delivering on its cost improvement programmes and generating sufficient resources to invest in its capital projects. Continued delivery of cost saving

measures through changes to workforce, estate, sustainability projects and service design are key in ensuring the Trust is able to meet its service and financial objectives. These workstreams form part of the organisation's change management programme.

The Trust needs to ensure it continues to deliver the local quality targets which have a contract value of £2.9m for 2011/12.

A Data Quality Action plan has been developed over 2010/11 to ensure systems and information are robust and effective in supporting service delivery and evidencing performance.

**Pension Liabilities**
The accounting policy for pensions is detailed in Note 8 of the Accounts and details of pensions paid to senior managers for the Trust are contained in Note 37 (the remuneration report). This report also contains details of benefits in kind made to senior managers.

**Prompt Payment of Invoices**
The Trust has signed up to the prompt payment code for the NHS and has met the better payment practice code which requires 95% of valid invoices to be paid within 30 days of receipt; details are in Note 22 in the Accounts.

The CBI better payments practice code requires organisations to pay invoices on time. The Trust performance against the NHS target demonstrates its compliance with this code. In November 2008 the government requested public sector organisations to pay small and medium sized suppliers within ten days of receipt of invoice to ensure these organisations had sufficient cash flow during the recession. The Trust responded to this request and paid over 92% of local suppliers within ten days.

The Trust was not required to make any payments to suppliers under the late payment of commercial debts (interest) Act 1998.

**Auditors Remuneration**
The Trust undertook a competitive tender for External Audit services in 2010/11. In October 2010 the contract for External Audit was changed as a result from Grant Thornton UK LLP to Deloitte LLP. The Audit fees were £5k and £65k respectively; this covers both the Annual Accounts and the audit of the Quality Accounts.

**Directors' Statement**
The Directors of the Trust can confirm that all relevant information has been made available to the foundation trust's auditors Deloitte LLP; for the purposes of their audit. In addition that they have taken all steps required to ensure their directors duties are exercised with reasonable care, skill and diligence.

So far as any Director is aware, there is no relevant information of which the Trust's auditor is unaware. Each Director has taken all the steps they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

**Going Concern**
The senior management and non executives of the Trust have inherently considered the matter of the Trust as a going concern, through the ongoing assessment of the resources needed to ensure it continues in operational existence for the foreseeable future. During 2010/11 the Trust prepared a detailed long term financial model, which was subject to independent review and showed projected surpluses for the next five years. As part of this, the Board has explored, in detail, the Trust's position, reviewing the financial viability of the

organisation in the challenging economic climate and the community service acquisitions. For this reason, the Trust continues to adopt the Going Concern basis in preparing the accounts.

**Capital Programme (including Estates Strategy)**
The Trust has taken forward and delivered a significant capital programme over the past few years, with the majority of capital expenditure focussed on the Fieldhead hospital site to facilitate the re-provision of Low Secure services for both Adults and Learning Disabilities from St. Luke's in Huddersfield and relocation of inpatient and community services in Kirklees. The Trust has been developing its Estates Strategy during 2010/11 which will be presented to the Board in 2011/12.

**Regulatory Compliance**
The Trust will continue to ensure it has ongoing regulatory compliance, with the relevant processes, procedures, assurance and oversight in place to allow the early identification of potential breaches, taking action where necessary.

This will include, but is not limited to:

- service performance;
- clinical quality and governance;
- governance processes and procedures;
- financial stability, profitability and liquidity;
- risk to the provision of mandatory services;
- NHS Constitution
- ongoing registration with the Care Quality Commission.

Key regulatory risks in the coming year include the following.

- Ensuring the legality of the Trust's constitution.
- Failure to meet the requirements of Monitor's Compliance Framework.
- Inability to secure unconditional registration with Care Quality Commission.
- Impact of acquisition of services through TCS on compliance targets.
- Trust will not meet compliance requirements for data quality.
- Inability to meet financial targets due to uncertainty of emerging government policy on commissioning, competition and collaboration in health markets, changes in VAT, pay awards and rates for dividend payments which may destabilise the planned revenue and cash position of the Trust. This would have an adverse impact on the Trust's Financial Risk Rating and could result in failure to meet Monitor compliance requirements.
- Maintaining positive performance during a time of significant organisational change.
- Trust will not meet compliance requirements for data completeness on HONOS.

Mitigating action is in place to address the anticipated regulatory risks to the Trust in 2011/12.

## Other disclosures

Equality and diversity
We are fully committed to supporting and promoting diversity and equality both in the way we provide services and as an employer. We aim to ensure that all our services are designed and managed to respect and value difference. Our diversity strategy and other policies recognise that diversity and equality is core to the way we work and provide services and that we must maximise people's potential through valuing their diversity and treating them equally. It also acknowledges that people who come into contact with our services, or

who work for us, are individuals and are not defined by one aspect of their lives, whether that is their race, gender, sexual orientation, religion or any other categorisation.

Our strategies and policies around diversity and equality help us to continue to promote a culture where the individuality of our service users and staff is respected. They also help us continue on our journey to become a 'diversity competent' organisation.

To be diversity competent, we need to:

- meet the needs of people from diverse backgrounds - for example gender, religion, language, sexuality;
- recognise what those needs are and have the skills and resources to provide the right services;
- not make decisions or mistakes based on stereotypes and ignorance.

Only by valuing diversity and recognising its importance in our services, our approach and our workforce will we be able to meet the positive challenges associated with equality in the 21st century and maximise people's potential.

Health and safety

Trust Board acknowledges that the health, safety and welfare of our staff, patients, partners, clients, residents, visitors and external contractors is of paramount importance. The Trust has a policy in place that recognises that everyone has a role in the provision of a safe working environment and also that, wherever staff work, the Trust has a responsibility towards their health and safety while they are at work either within Trust premises or at any other location.

Our Health and Safety Policy reflects the Trust's mission, vision, values and goals and the commitment to balance risks, rights and responsibilities and ensuring working environments are safe as possible. Integral to the policy is the Trust's goals of establishing clear and effective ways to manage and develop health and safety in the Trust and ensuring this is supported through clear organisational policies, framework, communication and standards.

The policy reflects the Trust's ethos of ensuring equal opportunities and a safe, secure environment as far as reasonably practicable for stakeholders regardless of race, nationality, gender, culture, beliefs, sexual orientation, age or any disability including mental health problems. This policy ensures the Trust adheres to Health and Safety Executive guidelines and meets its statutory and regulatory obligations in relation to health and safety.

There have been no enforcement or prohibition notices against the Trust in 2010/11.

Information on the Trust's policies on health and safety can be found on its website.

The Trust offers an occupational health service to its staff in partnership with Leeds Partnerships NHS Foundation Trust.

Fraud and corruption

The Trust commissions Local Counter Fraud Specialist (LCFS) expertise from our Internal Audit Provider, West Yorkshire Audit Consortium. During the year, the LCFS has reviewed the following policies and protocols as part of the annual work plan, which is approved and monitored by the Audit Committee.

- Fraud and Corruption Policy;

- Local Counter Fraud Specialist/Local Security Management Specialist Protocol;
- Local Counter Fraud Specialist/Human Resources Protocol;
- Redress Protocol;
- Counter Fraud Communications Strategy.

Fraud prevention risk reviews have also been conducted looking at the following areas.

- Staff bank
- E-rostering
- Patients' Property

The aim of this work is to address areas where fiscal loss is an increased risk and also to update standard operating policy/protocol documents. Clear protocols have greater importance as the majority of criminal investigation work transfers to Trusts.

This activity ensures Trust staff have up-to-date documents to refer to that are legally and procedurally correct in order to assist day to day work. Key fraud risks can be prevented by action on recommendations made in reports to strengthen systems and working arrangements. This has taken place in terms of e-rostering and staff bank.

Policy and protocol work also confirms official reporting channels and LCFS contact information, raising profile and awareness. The use of actual case examples at the Trust in publicity articles has demonstrated to staff that the Trust is active against those who choose to commit fraud. This may prevent fraud by providing deterrence.

Having a clear policy and information relating to fraud investigation work and a HR protocol, that set out responsibilities, the Trust has been effective in applying both criminal and disciplinary sanctions during 2010/11.

Consultations completed in previous year (2009/10), consultations during 2010/11 and any planned consultations in 2011/12

No formal consultations were undertaken during the past two financial years and there are no consultations in progress at the date of this report. However, the Trust has in place processes for ongoing update and engagement with people who use services and their carers through dialogue groups in each area and through groups established to secure involvement in specific projects. In 2010/11, this worked well supporting the relocation of services from the St Luke's Hospital site to improved inpatient and community accommodation (see below) and in medium secure forensic services regarding the redevelopment of facilities to improve the care environment and the service pathway.

In 2011/12, the Trust plans to review the service offer, revising the model to improve access and ensure a more person centred approach to delivery. Service users will influence this work through a range of involvement activity. Following the relocation of services from the St. Luke's site, the Trust will review the long-term provision of in-patient services in Kirklees and will undertake a consultation with service users and carers, the Members' Council, members, staff and the wider public through a series of workshops and focus groups during the summer and autumn of 2011.

Consultation with local groups and organisations, including O&S covering membership areas and other involvement activities

The Trust has developed a model of good practice around how we consult with service users, carers and our broader membership on new projects and larger developments as follows.

- Initial ideas and discussions are taken to the relevant service user or carer dialogue groups.
- Following this, people who attend dialogue groups and people from our membership involvement database are invited to a more detailed focus group. This group reviews the proposal in more detail and starts to develop work streams for the different parts of the project. The people who attend the focus group are offered places on the different work streams.
- Updates on progress are presented at dialogue groups at regular intervals.
- In parallel to this process, Equality Impact Assessments are started and service users and carers are involved in any action plans developed from the equality issues identified.

This model was tested in 2010/11 as part of the St Luke's re-provision project and proved very effective in managing anxieties, issues and ensuring the process was service user and carer-led. An additional public consultation at Huddersfield Town Hall was also integrated into the process, which added an extra dimension of public involvement into the process. This model will be used for all future service development and driven through the local Equality and Inclusion Action Groups.

During 2010/11, we used a similar process for the development of the Involving People and Creative Minds Strategies using the Members' Council as the main driver for involving service users and carers. We met initially with a group of volunteers from the Member's Council who helped us plan our communications and workshops to take the strategies forward. Council Members helped us to facilitate and run the workshops with service users and carers, which demonstrated a collaborative approach and ensured ownership of the agenda to Council Members. This model of good practice will be encouraged throughout the organisation and promoted through the local Equality and Inclusion Action Groups.

Details of any serious incidents involving data loss or confidentiality breach

There were no serious incidents involving personal data as reported to the Information Commissioner's Office in 2010/11 (graded 3 to 5 severity on Department of Health criteria).

There were three personal data related incidents (graded 1 or 2 on Department of Health criteria) in 2010/11. These related to loss of inadequately protected electronic equipment devises or paper documents from outside secured NHS premises (one incident) and the category of 'other' for two incidents. It should be noted that one of these incidents was reported retrospectively in April 2011 following a review of the incident although the incident occurred in February 2011. Robust action was taken in relation to all three incidents.

# Looking Ahead

We are committed to providing the best quality services that are safe and effective and focused on improving the experience of people who need our care and on delivering maximum value for money. We actively promote a culture of commitment to achieving the best possible service outcomes and improvements for service users – delivering the right services, of the right quality at the right time to support recovery and wellbeing.

**Our strategic priorities**

This is a challenging time for the NHS, with organisations required to identify savings, provide 'more for less', transform services and improve productivity and quality. This requirement to change the way services are delivered is not only driven by financial necessity but also by national policy. The publication of New Horizons, a dynamic new approach to promoting good mental health and well-being, increases the focus on delivering personalised care through personal budgets. The National Dementia strategy promotes increased awareness, early diagnosis and intervention and self-directed care.

Successful organisations need to demonstrate strong partnership working, that they have robust plans in place which are innovative, credible and flexible and that they can deliver services that are best value for money.

Our mission and values moving into 2011/12 remain the same ensuring that we enable people with health problems and learning disabilities to live life to the full. The Trust's mission articulates the ambition of the Trust at the highest level and, in response, Trust Board has reviewed its five key strategic priorities, aimed at maximising the inherent potential of the organisation within a rapidly changing NHS.

| **Key strategic priority** | Action |
|---|---|
| To expand and consolidate the Trust's role in the delivery of local pathways. | The consolidation of local pathways has continued with service and performance improvement in all localities, evidenced by improved reference costs and delivery of key performance indicators set by Trust Board. In addition, this has included incorporation of further community services in Calderdale and Wakefield. Sound partnership working has been at the heart of this, leading to achievements of strong contractual positions in all areas, supported by district based management via Business Delivery Units (BDUs) and a robust change management programme. |
| To utilise expertise to develop specialist services. | In relation to Specialist Services, the Attention Deficit Hyperactivity Disorder (ADHD) service has continued to flourish and a senior clinician has been appointed to identify areas for potential expansion. |
| To expand the Trust's role in Forensic Services. | The Forensic Service has identified priorities for expansion and redevelopment. This has included the development and Trust Board approval of a business case for ten further beds and significant refurbishment of existing facilities which has been welcomed by Specialist Commissioners. As a result the Trust will have the largest market share for Forensic Services in the region. Relationships with commissioners remain positive and robust, based on delivery of key performance targets. |
| To develop the Quality Academy, fulfilling our | The development of the Quality Academy |

| Key strategic priority | Action |
|---|---|
| ambition to be a 'thought leader'. | approach (QA) has focused on harnessing the optimum Support Service offer. In support of this, the Trust has continued its relationship with the Jonkoping community in Sweden, appointed an Assistant Director to support QA development and embarked on a lean systems programme Trust-wide. |
| To consolidate the geographical expansion of the Trust into Barnsley. | During 2011 the Trust has successfully acquired services from Barnsley, Calderdale and Wakefield under the Transforming Community Services (TCS) initiative. In particular, the acquisition of Barnsley community services and mental health services represents a significant transaction for increasing turnover by 71%. This transaction has been assessed by Monitor and rated 3 for financial risk and green for governance. The acquisition has been approved by Trust Board and the services transferred on 1 May 2011. |

To deliver this we need a comprehensive and integrated approach to organisational development, based on a clear strategic framework. The 4+4 framework "What Really Works" *(Nohria, Joyce, Roberson)* has served the organisation well to-date and provides the basis for the coming year's objectives, ensuring a balanced approach to all aspects of organisational function.

Our strategic framework and corporate objectives 2011/12 at Trust board level are as follows.

1. **Revise our service offer**, aiming to put service users in control of their care and lives, seeing them report high satisfaction with the outcomes they achieve.
2. **Provide strong leadership to the health and social care economies** both locally and wider, enhancing organisational reputation and competitiveness through demonstrably effective approaches to quality improvement, innovation, health prioritisation and preventative work.
3. **Live the values of the organisation**, achieving best practice in service development through a process of leadership, listening, learning and effective monitoring of performance.
4. **Extend the role of the Trust into broader community services** in Barnsley, Calderdale and Wakefield, developing a strong reputation for improved pathway based services which make a real difference to people's lives, occupying a lead role in developing health and wellbeing for the most disadvantaged groups.
5. **Enhance the Trust's reputation as a specialist provider of Forensic Services** through effective redevelopment and expansion of services and strengthening the role as a system leader through national work on service classification and currency.
6. **Support service development in line with best practice**, fostering innovative approaches to care supported by our Quality Academy, aiming to produce the best possible outcomes for service users in the most efficient way, evidenced through delivery of key performance indicators.
7. **Develop effective relationships with partner agencies and GP commissioners**, supporting the vision of the Trust as a provider of choice.
8. **Continue the development of the Trust Board and Members' Council**, focussed on performance improvement in a climate of increased autonomy and limited central control.

9. **Continue to manage finance, workforce, estate and information technology to the highest standard** in support of the service offer, strengthening competitive advantage in a changing provider landscape.

These support our strategic outcomes, which seek to:

- improve the health and wellbeing of our service users and influence the wellbeing of the communities we serve;
- manage risk and deliver safe, high quality services;
- improve the service user experience, engaging them in the design and delivery of services;
- ensure that the Trust remains viable and sustainable, into the future;
- improve the efficiency and productivity of our services in line with best evidenced based practice.

In the next three years, the Trust will adhere to its' terms of authorisation, remain well governed, legally constituted and financially viable and sustainable delivering on key targets set out in its Business Plan as well as delivering against Monitor's compliance framework. In doing so it is the Trust's ambition to be viewed as a national and international leader in the field of community provision, utilising the freedoms and flexibilities of Foundation Trust status to achieve this goal.

Key external impacts likely to affect future development, performance and the position of the Trust are as follows. Mitigating action is outlined in the Trust's annual plan for 2011/12.

| Key External Impact |
|---|
| Financial challenge related to "flat cash" allocations from commissioners from 2011/12 onwards. |
| Potential decommissioning of services and uncertainty around role of commissioners creating an environment where services are more likely to be de-commissioned from the Trust. |
| Impact of change of government and increased role of GPs through Practice Based Commissioning. |
| Impact of the implementation of Care Pathways and Packages Programme to introduce PbR for mental health services by the Department of Health. |
| Impact of differential PCT strategic approaches to the Transforming Community Services agenda. |
| Political and reputation risks related to Estates rationalisation. |
| Impact of demographics and recession - increased elderly population and potential increased unemployment. |
| Implementation of Putting People First in Local Authorities impacting upon integrated service provision. |
| Impact of national pay awards on workforce and workforce relations. |
| Impact of Specialist Commissioning Group benchmarking exercise to review forensic commissioning with a potential competitive tendering process. |

**Statement of the Chief Executive's responsibilities as the accounting officer of South West Yorkshire Partnership NHS Foundation Trust**

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed South West Yorkshire Partnership NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of South West Yorkshire Partnership NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's *NHS Foundation Trust Accounting Officer Memorandum*.

Signed… 

**Chief Executive**

## Annual Governance Statement 2010/11
## (Formerly Statement on Internal Control)

### Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum.*

I have a duty of partnership to discharge, and therefore work collaboratively with other partner organisations. The Trust is fully involved in partnership arrangements with the three Local Authorities and three Primary Care Trusts who share our geographical boundaries. Sound relationships continue to exist with the three PCTs, Local Authorities and the Forensic Commissioning Consortium; this is a critical factor in supporting the Trust's future success. Good links continue with NHS Yorkshire and the Humber through the Chief Executives' and Chairs' forums and regular Chief Executive to Chief Executive contact. All Executive Directors are fully engaged in relevant networks, including nursing, medical, finance and human resources. As part of the Transforming Community Services agenda and the planned transfer of Care Services Direct in line with the Trust's strategic objectives (the provider arm of NHS Barnsley) to the Trust on 1 May 2011 (subject to Monitor risk assessment and Trust Board approval), the Trust has been working closely with NHS Barnsley and Barnsley Metropolitan Borough Council to ensure alignment and safe transfer of services.

As Chief Executive of the Trust, either I or nominated directors have attended formal Overview and Scrutiny Committees in each of the three Local Authorities and have met informally with the Chairs of each of the Committees to update on the Trust's strategic direction.

### The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level, rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of South West Yorkshire Partnership NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Trust for the year ended 31 March 2011, and up to the date of approval of the Annual Report and accounts.

### Capacity to handle risk

Since taking on the role of Accounting Officer I have embedded an evidence based framework for organisational development and internal control: "What really works: the 4+2 formula for sustained business success – Nohria, Joyce and Robertson". This is based on an extensive piece of research undertaken through Harvard Business School identifying critical success factors in over a hundred US companies. The use of this model has since been advocated by the NHS Leadership Centre. The framework identifies four essential primary practices: strategy, flawless execution of strategy, culture and structure and two of four secondary practices at which the organisation must excel. Two from four of:

innovation, partnerships, leadership and talent development. The model has provided a framework for principal objectives to be agreed and set by the Board and implementation objectives to be determined in line with key executive director accountabilities. These objectives have been reviewed by me with individual directors on a quarterly basis. Any resulting amendments to the Assurance Framework are reported directly into the Trust Board including any changes to the organisational risk register.

The Trust works within a framework that devolves responsibility and accountability throughout the organisation by having robust service delivery arrangements, discharged for the period up to 31 October 2010 by Service Delivery Groups covering adults of a working age, older people, people with a learning disability and people who require specialist medium secure services. From 1 November 2010, this was delivered through Business Delivery Units (BDUs) covering Calderdale, Wakefield, Kirklees and Forensics, underpinned through Service Line Management at service delivery level.

Training needs of staff in relation to risk management are assessed through a formal training needs analysis process, staff receiving training appropriate to their authority and duties. The role of individual staff in managing risk is also supported by a framework of policies and procedures which promote learning from experience and sharing of good practice.

The Trust has a Risk Register in place which outlines the key strategic risks for the organisation and action identified to mitigate these risks. This is reviewed on a regular basis by the Executive Management Team (EMT) and Trust Board, providing leadership to the risk management process. Risk Registers are also developed at service delivery level within BDUs and within support directorates, again being subject to regular reviews in line with Trust Strategy and monitored through the monthly Extended EMT, including opportunity to share concerns and good practice.

**The risk and control framework**

Trust Board has the overall responsibility for probity (standards of public behaviour) within the Trust and is accountable for monitoring the organisation against the agreed direction and ensuring corrective action is taken where necessary.

The Chief Executive remains accountable, but delegates executive responsibility to the Executive Directors of the Trust for the delivery of the organisational objectives, while ensuring that there is a high standard of public accountability, probity and performance management. The personal objectives of each director have clear risk and assurance statements attached to them. The Assurance Framework reflects the strategic objectives assigned to the Executive Directors.

Agenda setting ensures that the Board is confident that systems and processes are in place to enable individual, corporate and, where appropriate, team accountability for the delivery of high quality person-centred care. The cycle of Trust Board meetings has been reviewed during the last year to ensure the Board devotes sufficient time to setting and reviewing strategy and monitoring key risks. Within each quarterly cycle, there will be one meeting with a focus on business risk and performance, one formal public meeting and one strategic development session.

Strategic risk is managed in line with the Trust's Risk Management Strategy which was amended and approved by the Trust Board in October 2010 to reflect challenges in the external environment and the need to manage risk associated with devolution of responsibility into BDUs, which, following a period of running in a shadow format, become operational on 1 November 2010. The strategy sets out specific responsibilities and accountabilities for the identification, evaluation, recording, reporting and mitigation of risk in

accordance with the ALARM principle to reduce risk to as low as reasonably practical. The Trust's risk matrix sets out those risks which, under this principle, are tolerable from those which are unacceptable. The Trust's main risks as set out in the organisational risk register are as follows.

- Impact of Local Authority funding cuts resulting in reduction of the social care workforce and increased pressure on health services and the ability of integrated teams to meet performance targets, mitigated through the establishment of district integrated governance boards, introduction of revised leadership and management arrangements within BDUs.
- Data quality and capture of clinical information on RiO (the Trust's clinical information system) will be insufficient to evidence compliance with the Monitor Compliance Framework, mitigated through implementation of an action plan arising from a data quality assurance review, implementation plan for 'Top 10 RiO tips', inclusion of metrics on data quality in Trust Board reports and performance management.
- Risk that services transferring under the TCS agenda contain clinical, financial and operational risks, mitigated through due diligence work undertaken by KPMG and Hempsons, which identified key issues, and addressing these through indemnities and warranties in Business Transfer Agreements and contract negotiations.
- Reduction in PCT allocations, with increased financial pressures across health economies leading to a reduction in income and unfunded service pressures, mitigated by a methodology for risk and benefits sharing agreed in principle with commissioners and developing joint QIPP plan with PCTs. The Trust's annual plan includes contingency to cover unplanned reductions.

Innovation and learning in relation to risk management is critical. The Trust's e-based reporting system, Datix, has been rolled out to all clinical and non-clinical areas in the organisation so that incidents can be input at source and data can be interrogated through ward, team and locality processes, thus encouraging local ownership and accountability for incident management. The Trust identifies and makes improvements as a result of incidents and near misses in order to ensure it learns lessons and closes the loop by improving safety for service users, staff and visitors. The Trust operates within a just, honest and open culture where staff are assured they will be treated fairly and with openness and honesty when they report adverse incidents or mistakes.

The Trust works closely with the National Patient Safety Agency (NPSA) patient safety manager. The Trust uses Root Cause Analysis (RCA) as a tool to undertake structured investigation into serious incidents (formerly known as serious and untoward incidents (SUIs) with the aim of identifying the true cause of what happened, to identify the actions necessary to prevent recurrence and to ensure the Trust takes every opportunity to learn and develop from an incident. The Trust continues to build on the pool of staff trained by external facilitators and has supported key clinicians and managers to attend RCA training, including training provided by the NPSA. Staff who are now trained to facilitate RCA are part of a learning set to further develop their skills, provide support, and maintain an overview of the implementation of systems to support RCA in the organisation.

The Clinical Governance and Clinical Safety Committee monitors the implementation of recommendations arising from independent inquiries until all actions have been completed and closed by the SHA.

The provision of Mental Health Services carries a significant inherent risk, which results on occasions in serious incidents which require robust and well governed organisational controls. During 2010/11 there have been 26 SIs; during 2009/10 there were 28 SIs. SIs (2007/5748, 2008/1621 and 2008/20741) are subject to external review undertaken by the Health and Social Care Advisory Service (HASCAS) under HSC 94/27 (Independent

Investigations of Adverse Events in Mental Health Services). The reviews were instigated by the NHS Yorkshire and the Humber and NHS Kirklees in September 2010 and relate to incidents which occurred between 2006 and 2008. The anticipated report date is May/June 2011.

In all instances where a serious incident has occurred, the Trust provides a robust internal response through the Root Cause Analysis process. The findings of all SI investigations are analysed to identify any trends or consistent issues. Action plans have been monitored directly through Trust Board and through the Clinical Governance and Clinical Safety Committee.

Control measures are in place to ensure that risks to data security are identified, managed and controlled. The Trust has put an information risk management process in place led by the Trust SIRO (senior information risk owner). Information asset owners have been identified to cover the Trust's main systems and records stores, along with information held at team level. An annual information risk assessment is required. All Trust laptops and memory sticks are encrypted and person identifiable information is required to be only held on secure Trust servers. The Trust is aiming to get all staff to complete training on information governance by June 2011 and messages on compliance with Trust policy have been backed up by a number of items in the Team Brief. Incidents and risk are reviewed by the Information Governance Trust Action Group chaired by the Trust SIRO, which inform policy changes and reminders to staff.
Between January 2010 and December 2010, there was one level 3 incident and 2 lower level incidents (1-5 scale, 5 being the most serious). The level 3 incident was reported to the SHA and the Information Commissioner's Office in accordance with procedure. Unauthorised access was made to 55 service user records held electronically. The member of staff concerned, who was employed by a local authority, has been disciplined. Systems have been reviewed to mitigate, manage and control any further incidents of a similar nature.

The Trust works closely with public stakeholders to involve them in understanding and supporting the management of risks that impact upon them. Stakeholders are able to influence the Trust in a number of ways, including patient involvement groups, public involvement in the activities of our Trust, and regular dialogue with MPs and other partners.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with through Trust policies, training and audit processes, ensuring equality impact assessments are undertaken and published for all new and revised policies and services. The Trust has adopted the approach that new or revised polices, strategies, service redesign and projects must require to undertake Equality Impact Assessment before EMT and Trust Board approval. This has ensured that equality; diversity and human rights issues and service user involvement are being systematically considered and delivered on core Trust Business. The Trust is on target for 100% of all commissioned services to have had an EIA by the end of March 2011. Through the newly established Equality and Inclusion Planning and Contracting group, the Trust will ensure EIAs are fully mainstreamed into BDUs performance framework.

As an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

The Trust has undertaken risk assessments and developed an Adaption Plan to support its emergency preparedness and civil contingency requirements, based on UK Climate

Projections 2009 (UKC P09), to ensure that this organisation's obligations under the Climate Change Act are met.

The Trust is assured that it is fully compliant with Care Quality Commission (CQC) registration requirements through regular internal regulatory compliance review processes and a continuing low risk of non-compliance rating by the CQC as evidenced via the Trust's Quality and Risk Profile.

The Trust has assessed itself against the NHS Constitution and meets all the rights and the pledges with the exception of the pledge "The NHS commits to make the transition as smooth as possible when you are referred between services, and to include you in the relevant discussions". It meets this partly as the Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there are occasions when the nature of an individual's illness makes this inappropriate

The key elements of the Trust's quality governance arrangements are as follows.

- The Trust's Quality Improvement Strategy reinforces the commitment to quality care that is safe, person-centred, efficient and effective. The strategy specifies the responsibilities held by individuals, BDU and Local Management Teams, the Executive Management Team and Trust Board, co-ordinated under the Quality Academy. The Clinical Governance and Clinical Safety Committee is the lead committee for quality governance.
- There are quarterly quality and compliance reports for Trust Board and Executive Management Team as well as monthly compliance reporting against quality indicators within performance reports
- CQC regulation leads monitor performance against CQC regulations and the Trust undertakes a twice yearly self-assessment.
- External validation, accreditation, assessment and quality schemes support self-assessment (for example, accreditation of ECT, PICU and Memory Services; CQC/Mental Health Act Visits; NHSLARMS status; National Surveys (staff and service user); Implementation of Essence of Care and Productive Ward, etc.)
- Trust Action Groups provide organisational overview and performance monitoring against key areas of governance such as SIs, Infection Prevention and Control, Information Governance, Management of Aggression and Violence, Drugs and Therapeutics and Practice Effectiveness.
- Measures are implemented and maintained to ensure practice and services are reviewed and improvements identified and delivered, such as the Trust's prioritised clinical audit and practice evaluation programme.
- Learning from patient experience via local surveys, complaints and involvement groups.

**Review of economy, efficiency and effectiveness of the use of resources**

The Executive Management Team has a robust governance structure ensuring monitoring and control of the efficient and effective use of the Trust's resources. Financial monitoring, service performance, quality and workforce information is scrutinised at meetings of the Trust Board, Performance EMT, BDU management teams and at various operational team meetings. The Trust is a member of the NHS Benchmarking Network and participates in a number of benchmarking exercises annually. This information is used along side reference cost and other benchmarking metrics to review specific areas of service in an attempt to target future efficiency savings. This work will be enhanced further during 2011/12 in areas such as service line reporting and work being undertaken internally and with partners on the quality, innovation, productivity and prevention (QIPP) agenda.

The Trust has a well developed annual planning process which considers the resources required to deliver the organisation's service plans in support of the strategic objectives.

These annual plans detail the workforce and financial resources required to deliver the service objectives and include the identification of cost savings. The achievement of the Trust's financial plan is dependant upon the delivery of these savings.
As part of the annual accounts review, the Trust's efficiency and effectiveness of its use of resources in delivering clinical services are assessed by its external auditors and the auditor's opinion is published with the accounts.

**Annual Quality Report**
Trust Board is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports, which incorporate the above legal requirements in the *NHS Foundation Trust Reporting Manual*. The following steps have been put in place to assure Trust Board that the Quality Report presents a balanced view and that there are appropriate quality governance arrangements in place to ensure the quality and accuracy of performance information (the data).

- Governance and leadership
  There is clear corporate leadership of data quality through the Deputy Chief Executive/Director of Finance with data quality objectives linked to business objectives, supported by the Trust's data quality policy and evidenced through the Trust's Information Assurance Framework, Information Governance Toolkit action plans and updates. The commitment to, and responsibility for, data quality by all staff is clearly communicated through Trust induction, IM&T Strategy, Data Quality Policy and RiO training.
- Policies
  There is comprehensive guidance for staff on data quality, collection, recording, analysis and reporting which meets the requirements of national standards, translating corporate commitment into consistent practice, through the Data Quality Policy and associated IM&T policies. There are performance and information procedures for all internal and external reporting. Mechanisms are in place to ensure compliance through the Information Governance TAG and annual reports to the Audit Committee on data quality.
- Systems and processes
  There are systems and processes in place for the collection, recording, analysis and reporting of data which are accurate, valid, reliable, timely, relevant and complete through system documentation, guides, policies and training. Corporate security and recovery arrangements are in place with regular tests of business critical systems.
- People and skills
  Roles and responsibilities in relation to data quality are clearly defined and documented, with data quality responsibilities referenced within the Trust's induction programme. There is a clear RiO training strategy with the provision of targeted training and support to ensure responsible staff have the necessary capacity and skills.
- Data use and reporting
  Data provision is reviewed regularly to ensure it is aligned to the internal and external needs of the Trust through Performance EMT and Trust Board, with KPIs set at both service and Board level.

  As part of the ongoing development of the 2010/11 Quality Report, the Trust has reviewed the systems of internal control with no significant weaknesses or gaps having been identified

  The External Auditors will be providing external assurance on the Quality Report and the findings will be presented to the Audit Committee, Clinical Governance and Clinical Risk Committee, Trust Board and shared with the Trust's Members' Council.

**Review of effectiveness**

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the South West Yorkshire Partnership NHS Foundation Trust that have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by Trust Board, the Audit Committee, the Clinical Governance and Clinical Safety Committee, clinical audit, internal and external audit and by my Executive Management Team. Plans to address any weaknesses and ensure continuous improvement of the system are in place. Satisfactory assurances have been received with the exception of Clinical Audit (limited assurance) where the framework for supporting delivery reporting and monitoring of the audit programme was considered lacking in clarity and transparency. Subsequently, the Trust has implemented an improvement plan as part of which a new strategic framework and policy for clinical audit and practice evaluation has been produced. In 2010/11 policy implementation, establishment of a specific Trust Clinical Audit and Practice Evaluation Group and improved monitoring and reporting arrangements have all contributed to ensure Trust Board now receives more effective and robust assurance.

The Assurance Framework provides me with evidence that the effectiveness of controls put in place to manage the risks to the organisation achieving its principal objectives have been reviewed. The Assurance Framework has been reviewed and updated and approved by Trust Board on a quarterly basis throughout the past year. There were no significant gaps identified in the Assurance Framework.

Trust Board, as part of its assurance processes, reviewed the effectiveness of its governance arrangements through the 'Taking it on Trust' report from the Audit Commission and produced an action plan to address some minor issues.

My review is also informed by reports from external inspecting bodies including external audit and the PEAT audit. In addition, the effectiveness of internal control and risk management systems has been subject to external scrutiny and validation through the Monitor assessment process and by the independent accounting firm KPMG.

All Committees of Trust Board are chaired by Non-Executive Directors to reflect the need for independence and objectivity, ensuring that effective governance and controls are in place. This structure ensures that the performance of the organisation is fully scrutinised. The Committee structure supports the necessary control mechanisms throughout the Trust. The Committees have met regularly throughout the year and their minutes and annual reports are received by the Board.

The Audit Committee is charged with monitoring the effectiveness of internal control systems on behalf of the Board and has done so as part of its annual work programme and reported through its Annual Report to the Board.

The role of internal audit at the Trust is to provide an independent and objective opinion to me and my managers on the system of control and also the Trust Board. The opinion considers whether effective risk management, control and governance arrangements are in place in order to achieve the Trust's objectives. The work of internal audit is undertaken in compliance with the NHS Internal Audit Standards. The work to be undertaken by internal audit is detailed in a three year strategic audit plan and is reviewed annually to generate an annual audit programme. The audit programme includes a risk assessment of the Trust,

based on the Trust's assurance framework, an evaluation of other risks identified in the Trust's risk register and through discussion with management. Internal audit reports the findings of its work to management, and action plans are agreed to address any identified weaknesses. Internal audit findings are also reported to the Audit Committee for consideration and further action if significant. A follow up process is in place to ensure that agreed actions are implemented. Internal audit is required to identify any areas at the Audit Committee where it is felt that insufficient action is being taken to address risks and weaknesses. The Head of Internal Audits overall opinion for 2010/11 is that throughout the year Internal Audit has liaised closely with the Trust with regard to its Assurance Framework and has concluded that the methodology surrounding the design and operation of the framework is sound, and his overall opinion is that of significant assurance.

The Chief Executive is supported by the Executive Management Team, consisting of the Executive Directors. The EMT supports the Chief Executive to co-ordinate and prioritise activity in the Trust ensuring that the strategic direction, set by the Trust Board, is delivered. It is jointly responsible for ensuring that the agreed leadership and management arrangements are in place, supported by robust and clear governance and accountability processes. It ensures the organisation champions equality and that the Trust is 'diversity competent'.

**Conclusion**

I have reviewed the relevant evidence and assurances in respect of internal control. The Trust and its executive managers are alert to their accountabilities in respect of internal control. The Trust has had in place throughout the year an assurance framework, aligned to both our corporate objectives and the healthcare standards to assist the Board in the identification and management of risk.

With the exception of the internal control issues that I have outlined in this statement, which are not considered significant, my review confirms that Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

**……**

**Steven Michael**
**Chief Executive**
**3 June 2011**

With all of us in mind

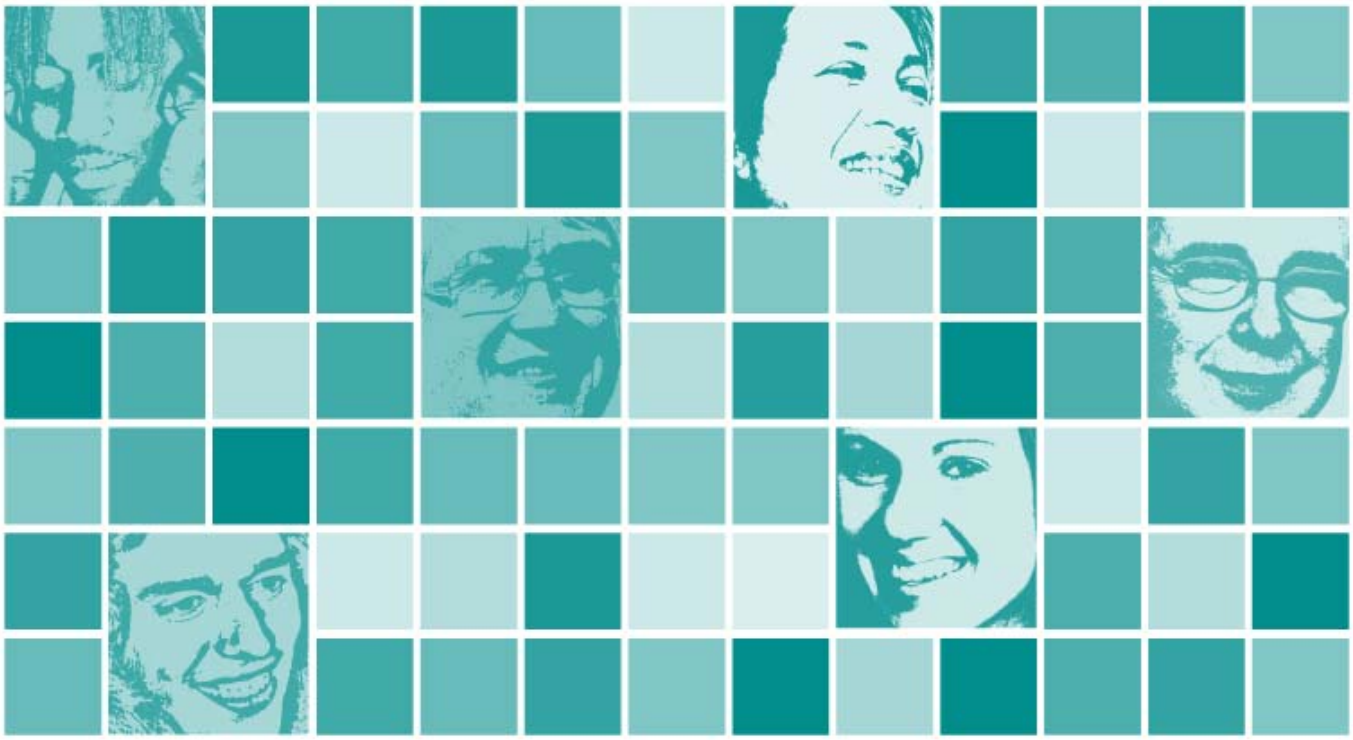
South West Yorkshire Partnership NHS
NHS Foundation Trust

# Quality Account
## 2010/2011

**Safety** **Service user experience** **Effectiveness**

# Contents

# Part 1



# 1.1 Statement on quality from the Chief Executive

The Quality Account is our annual report to the public about the quality of services we offer. It is our assessment of quality in 2010/11 across all the healthcare services we delivered and a statement of our ongoing commitment to maintain and improve quality. This report is for anyone who wants to know more about the quality of our services. People who might read it include those who use our services and their carers, our staff, commissioners, regulators and academics. Making information about the quality of our services available to the public means it is then open for scrutiny, debate and reflection; something we very much welcome.

During 2010-2011, the trust provided specialist mental health and learning disability services to the people of Calderdale, Kirklees and Wakefield and some secure (forensic) services to the whole of Yorkshire and the Humber. About 900,000 people live in Calderdale, Kirklees and Wakefield across urban and rural communities from a range of diverse backgrounds. During 2010/2011 we had direct contact with approximately 27,500 people, about 8,000 of whom were using our services for the first time. We work hard to ensure that our services are safe, effective and individually focused so that people can make choices about their care and move on from our services as soon as they are able. We try to support people to enjoy productive and independent lives and to have confidence that their care is of consistent high quality.

Throughout the year we have aimed to meet the expectations of our local communities and partners. We have also responded to national directives within the context of NHS change signposted in 'Equity and excellence: Liberating the NHS' DoH, 2010 and the national mental health strategy 'No Health without mental health' DoH 2011. Our quality objectives are informed by the 6 shared objectives within the national mental health strategy:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

Within this report we describe how we are continuing to meet the regulatory requirements set out by the Care Quality Commission and Monitor. We also say how we are addressing quality priorities identified by our commissioning Primary Care Trusts (PCTs) as specified within Commissioning for Quality and Innovation (CQUIN) schemes. Very importantly, we hope to demonstrate how we are striving to meet expectations of service users and carers. We are particularly keen to ensure we always uphold the principle of shared decision-making *'no decision about me without me'.*

Quality Accounts are both retrospective and forward looking. In Part 1 of this report we give examples of ways in which our services and teams have been delivering good quality care. There are many achievements to be proud of such as our services continuing to gain accreditation and building on best practice to implement the most effective care and treatment processes.

Throughout 2010/11 our staff worked hard to ensure that we upheld the quality domains: safety, service user experience and effectiveness. To maintain high standards the Trust strives to ensure that staff are well supported. This is in terms of their own physical and emotional wellbeing to provide staff with the resilience needed in a healthcare environment, as well as the capabilities to learn, develop and continue improving the quality of care provided.

To further promote involvement in service developments and decisions about care we have been listening to and learning from service user and carer dialogue groups, surveys, complaints and all other forms of feedback. We have continued to take a proactive role in promoting inclusivity, supporting employment opportunities and doing all we can to raise awareness and reduce stigma in regard to mental health and learning disability. We are also vigilant about safety; working hard to ensure best practice in regard to infection prevention, safeguarding, information governance and medicines management. However we recognise the need to learn from any events that have not been positive and so we have also highlighted some of the challenges we have encountered during the year.

In Part 2 we outline our quality priorities for 2011/2012 and describe how we came to identify these through engagement with a variety of people including service users, their carers, our clinicians, and our Members' Council. Throughout the year we have tried to deliver improvement against the priorities identified in our last quality report and in Part 3 we look back on our performance against quality priority targets in 2010/11.

This has been a challenging year for the Trust with a focus nationally for Primary Care Trusts (PCTs) to separate their commissioning functions from their provision of services. By May 2011, as part of the 'Transforming Community Services' initiative, we will have acquired a large number of community services from NHS Barnsley, NHS Calderdale and NHS Wakefield. Organisations taking on the responsibility for providing community services post April 2011 are required to publish a Quality Account detailing the quality of community services in 2010-2011. Therefore in Part 4 of the report we provide detail of the quality assessment and future aspirations of the services that have now been brought into the trust.

I hope you find this report both informative and interesting. We remain committed to achieving the best possible service outcomes and improvements for people who use our services.

*Steven Michael*
**Chief Executive**

## 1.2 Chief Executive Statement

As Chief Executive of South West Yorkshire Partnership NHS Foundation Trust, I can confirm that, to the best of my knowledge, all information in this document is correct.

Steven Michael
**Chief Executive**
**South West Yorkshire Partnership NHS Foundation Trust**

## 1.3 Quality Achievements and Priorities

Please see below a brief summary of some achievements in 2010/11 and our priorities going forward. More detail can be found within the body of this report.

**Table 1 Quality Achievements and Priorities**

| PRIORITY THEME 2010/11 | SOME ACHIEVEMENTS 10/11 | PRIORITY THEME 2011/12 | SPECIFIC PRIORITY FOR 2011/12 |
|---|---|---|---|
| **Improving practice - positive outcomes** | Robust workforce development programme aligned to the skills required for the delivery of the care pathway such as further development of non-medical prescribing. | **Access** | 1. Better definition and more effective integration of the role of the crisis and acute services |
| | Achievement of CQUIN indicators | | 2. Developing and implementing an effective single point of access (SPA) |
| | Implementation of productive mental health ward releasing more time for clinical care | **Pathways** | 3. Developing and supporting the role of the care co-ordinator |
| | Quality Improvement Strategy and Learning Development framework | | 4. Defining and measuring outcomes |
| | Assessment tool developed to support use of the recovery star. | | 5. Effective working with primary care and other providers |
| | Full clinical audit programme completed. Process developed to ensure planned audits fit with organisational objectives. | | |
| **Personalised Care** | Increase in the use of the befriending service | **Care and care planning** | 6. Better meeting physical health care needs |
| | CPA and personalised care plans support use of advanced directives | | 7. Implementation of the Recovery Star to underpin care planning |
| | | | 8. Improved focus on person centred care/individualised budgets/personal health budgets |
| **Mutual respect** | Reduction in complaints about staff attitude. | **Mutual respect** | 9. Measuring the service user experience and acting on it |
| | Update of web based information about the Trust and its services. | | 10. Increasing/improving customer care |
| **Environment & hotel services** | Positive Patient Environment Action Team (PEAT) results | **Environment** | 11. Maintenance of a clean, safe environment |
| | Productive MH ward Mealtimes module completed on some wards supporting changes to how mealtimes are managed. Protected time on wards during meal times. | | |
| | Regular patient experience questionnaires undertaken to understand issues related to accommodation for our service users. | | |
| **Suicide prevention and risk management** | Mandatory safeguarding training. Positive Ofsted report (Wakefield). | **Carers** | 12. Improving communication with carers of all ages |
| | Risk assessment and identification is incorporated into the CPA process. | | |
| | Suicide prevention conference hosted in November 2010. Investment in master class training in suicide prevention techniques. | | |
| | Maintaining 7 day follow up post-discharge | | |
| | Development and implementation of an Incident review committee to underpin learning | | |

## 1.4 Quality highlights and challenges in 2010/2011

Information presented in this part of the account relates to our overall review of quality performance which is more formally reported in part 3.

## 1.4.1 Effectiveness

**The Trust can evidence the quality of service delivery through accreditation processes and quality schemes. These require standards of excellence to be achieved which then directly impact on the quality of care.**

- In September 2010 the Electroconvulsive Therapy Service was re-accredited by the ECT accreditation service.
- The Wakefield memory service has been accredited as excellent by the Memory Services National Accreditation Programme (MSNAP).
- In October 2010 Kirklees Older People Services Practice Development Unit achieved stage 2 accreditation by the University of Leeds.
- The Psychiatric Intensive Care Unit achieved accreditation by the Royal College of Psychiatrists in January 2011.

Calderdale joint learning disability team operates as a satellite unit of the British Institute of Learning Disability to provide the Learning Disability Qualification. Inspected annually, the team again achieved the highest grade and are recognised as a Centre of Excellence. The external verifier commented that *'the trainers knowledge and experience was evident and the learners were extremely positive about their experience of training and assessment'.*

Many areas of the Trust are involved in Essence of Care (EoC) - a national initiative aimed at improving the fundamental and essential aspects of care crucial to the patient experience. Benchmarking activity is managed through an established and well structured monitoring group and helps practitioners take a structured approach to looking at practice and care. Performance is closely monitored with EoC champion work taking place within teams to maintain a group focus on quality and ensure that the care provided is meeting the standards required. Outcomes from EoC benchmarking have included: development of care home pre-referral packs to support health promotion for residents of care homes; introduction of life story work across older people, community, inpatient and care home settings; development of standards for privacy and dignity in all information packs in one care group; attendance at Makaton training sessions to improve communication within learning disability settings.

The 'Productive Mental Health Ward' programme involves all adult inpatient wards, one older people ward and 2 rehabilitation units. Focusing on efficiency staff are enabled to create an improved working environment which is also a safer one, as risks are reduced. The programme has fostered positive change in shift handovers, meal times, distributing medicine and improved patient well being.

**Innovative post and service developments have been made in response to national and local priorities, examples include:**

A Dementia Matron post developed in partnership with Calderdale and Huddersfield Foundation Trust (CHFT) focused on ways to reduce lengthy admissions to hospital and the number of people with dementia discharged to residential care. Since June 2010, the matron working with an associate nurse specialist for older people in CHFT has implemented pathways and care plans in 8 test bed sites with champions for these areas identified and trained. Evaluation has identified many positive benefits.

To bring unique treatment packages for Adults with Attention Deficit and Hyperactivity Disorder (ADHD) a multi-professional ADHD team was formed. The team showed their commitment to quality and performance by introducing person centred outcome measures based on the recovery approach, and has led the implementation of this approach Trustwide. As one service user commented *' I don't know where I would have been without this service"*

**Effective care pathways and packages are fundamental to the delivery of well managed co-ordinated quality care.**

A learning disabilities care pathway uses a single point of access to specialist health services for people with learning disabilities. All referrals are screened by senior clinicians to determine if the level of complexity requires a care coordinator or it can be passed directly to a relevant clinician. The care coordinator provides a single point of contact for the service user, their carers, care manager and others involved in their care and steers the person through the care process. GPs and acute hospital consultants have contributed to successful implementation by adopting the new system as their standard way of accessing the service.

Payment by Results for mental health involves service users allocated into care groups or clusters. For each cluster indicative care packages are developed with elements such as medical, nursing, and psychological interventions. In July 2009, a three phase research study began to develop more detailed Occupational Therapy (OT) indicative care packages as a collaborative project between our trust, South West London & St Georges Mental Health Trust, the University of Illinois at Chicago and Queen Margaret University Edinburgh. The research outputs are now available for use across English OT services. The document can be used as a detailed clinical tool and also provide a starting point for OT leads to engage in discussions with local commissioners.

**Effective care delivery can be seen in units and teams across the Trust.**

A 16 bedded assessment unit for older people with a range of acute mental health problems has been successfully involved in a pilot for productive ward and e-rostering. Whilst admission rates have remained static, average lengths of stay have shortened significantly and readmission rates are almost non-existent.

An acute hospital liaison team provides timely, responsive and high quality psychiatric assessments, interventions and care to older people admitted to a general hospital. The team helps to reduce stigma and promote equal access to appropriate services through role modelling opportunities and education – both ward-based micro-sessions and study days. A page on the acute trust's intranet site, quarterly newsletter and health care assistant development programme all contribute to general hospital staff raised awareness and training regarding mental health issues. The team's excellent work was praised by Professor Alistair Burns, national clinical director at a national liaison conference in May 2010.

**Effective support services are critical to the delivery of good quality care.**

The performance & information team is vital to keeping key clinical information systems running and ensuring that the Trust meets all its reporting requirements for external regulation. The service positively supports clinical staff in practice initiatives such as the implementation of the Productive Ward through the provision of user friendly graphics to display on wards. As one consultant psychiatrist commented '*I have been extremely impressed by the motivation, technical knowledge and day to day helpfulness of the P&I team … and so improving the range and quality of data available to clinical staff.'*

A re-designed mail service was launched with careful planning of each route and all Trust properties given a mail delivery timescale. The mail van drivers battled against some of the worst winter weather in 2010/11 but never failed to deliver on any day during that time.

**The Trust builds on identified best practice to implement the most effective assessment, care and treatment processes.**

The Trust's evidence-based Food and Nutrition Policies and Procedures (FNPP) provides guidance to ensure that service users admitted to the wards/units receive food that meets their nutritional and cultural needs, its purpose being to promote excellent nutrition for full mental health recovery. The FNPP, available on all in-patient units and the intranet now includes a Nutrition Risk Screening Tool. As one service user involved in the project commented *'This document is very beneficial to every service user who is admitted to in-patient areas of the Trust. It has been a revelation to us of the ongoing work behind the scenes on our behalf. Just to know that this work is happening is good to know.'*

In line with national evidence such as that cited by NICE regarding the effectiveness of Cognitive Behavioural Therapy (CBT) for people with psychosis the Early Intervention in Psychosis service offers a CBT therapy group. Evaluation demonstrates that group members find the approach helpful and that it promotes improvement in self esteem. *'I initially did not think it was going to be useful. I then enjoyed going and found it really helpful. I could voice my own opinions, and it helped with group working. It also helped me understand that there is not only me experiencing problems. I enjoyed listening to others and how they dealt with their situations. This has helped me try different ways to cope. Qualified staff were on hand to help when I felt I was struggling. It has controlled my thinking. I thought this was a good thing.'*

Over 12 months 80 people attended an annual health check up by a treatment & wellbeing team. Most had not attended for annual health assessment at their GPs so providing this service ensured that service users had their physical health needs prioritised and enabled safe medicines management. Many of the medical conditions identified needed urgent treatment and may have been present for some time. *'Since having my Annual Health check up I have been referred to Active for Life & lost 2 stones I have also cut down on the amount of alcohol I drink which has in turn improved my sleep no end. I would recommend this service for all as they gave me a thorough MOT which was long overdue'*

Addressing the absence of comprehensive and usable assessment tools that identify people's work capacity and readiness to return to work the work-ability profile was devised by two occupational therapists. The profile is based on the Model of Human Occupation (MoHO) and brings together the opinions of the service user and their supervisor, both having the opportunity to rate performance on a number of tasks and capacities. The work-ability profile is currently being trialled in a number of settings and has been well received by service users helping to confirm whether they are suited to a particular type of work and enabling work-related goals to be realistic, achievable and sustainable.

A multidisciplinary learning disability medicine group helps address the needs of this vulnerable group around prescribing, workforce knowledge and skills, innovation, audit, best practice and user/carer experiences. Since the group's inception the profile of medicines management has been raised so the needs of people with a learning disability are integral to all areas of practice. Good prescribing practice promotion includes: user information, managing epilepsy, challenging behaviour, health monitoring, rescue medication and teaching users about their conditions. Easy read medicines information is now being made available on the Trust's web site. Areas of research and innovation include an epilepsy medicines management study highly acclaimed by a national voluntary body.

An innovative project teaching new skills to health support workers in learning disability services and providing them with the underpinning knowledge to improve care via a work place evidence based process has proven very successful. The training packages and protocols are relevant in all areas carrying out basic health monitoring, ensuring more accurate measurement and more effective monitoring of the service user's physical condition. By enabling health support workers to carry out these interventions, some nursing time is released utilised for more skilled nursing activities.

**Trust staff are our most valuable asset and in order to provide high quality services they need physical and emotional resilience and opportunities to learn.** The practice element of nurse training provided the University of Huddersfield is delivered within the Trust. The Nursing and Midwifery Council (NMC) visited a number of teams and services across the Trust in January 2011 and assessed this as 'outstanding'.

The Trust is very aware of the effects of stress on mental wellbeing and offers staff the chance to take a funded 3 night wellbeing retreat in a venue in the Yorkshire Dales. Activities include meditation, mindfulness training, complementary therapies and Tai Chi with ample time allowed for individual reflection and walking in the surrounding countryside. Individual counselling is also available. All attendees complete an evaluation at the end of the retreat, followed up after one month and then at a later date. Participants report reduced stress levels, increased motivation, higher energy levels and greater self awareness. In addition, attendees say they have a more positive attitude to life and work and believe themselves better equipped to develop and sustain their own resilience in coping with pressures. *'Absolutely fantastic. I am blown away by how much the retreat has benefited me in every way. Having time on my own and with new friends to reflect was a highlight. I feel that after working for the Trust for 16 years it has given something back for all that I have given to it.'*

Nurse training provided by the University of Huddersfield is well supported by the Trust. The practice element of the nurse training provided by the University of Huddersfield is delivered within the Trust. The Nursing and Midwifery Council (NMC) visited a number of teams and services across the Trust in January 2011 and assessed this as 'outstanding'.

In 2009 the Trust opened a new eLearning suite with an initial eLearning portfolio of six courses which was expanded in February 2010 to include safeguarding adults and an introduction to mental health capacity act courses. An intranet page and input to the Trust's induction programme ensures all staff are aware of the eLearning opportunities. *'I was very interested by the raising mental health awareness course and the way it took the perspective of people experiencing mental health problems. I feel I have learnt a lot from this*.'

Sickness absence in 2010 was successfully reduced to the lowest in Yorkshire & Humber for mental health trusts and the national staff survey placed us in the top 20% of trusts for workplace pressure and staff recommending the organisation as a place to work or be treated. We have sought a new model of wellbeing relating to long term service and financial sustainability through building organisational, team and individual resilience. The Trust, working in partnership with Bradford District Care Trust, commissioned Occupational Psychologists Robertson Cooper to conduct a detailed wellbeing at work survey which will be repeated in 2011 to assess the effectiveness of the interventions taken.

Key findings from the 2009 national staff survey placed the Trust in the top 20% for access to training, health and safety training and commitment to work-life balance. However, we were in the bottom 20% for staff receiving appraisal. A new appraisal system has been introduced, an e-learning diversity training package is available and work related injuries are closely monitored. Results from the 2010 staff survey are showing significant improvement in numbers of staff appraised (up to 80%).

Working in partnership with 'Right Management' the Trust is developing a set of leadership and management competencies to support transformational change. All heads of service, clinical leads and general managers are undertaking a tailored development programme beginning with 360° review with skilled feedback provided on the analysed results. A two day development centre informs individually tailored development programmes.

The Trust's Quality Academy approach includes all support services to provide tools and services to front line staff and teams. This year the focus has been on defining the "offer" around four themes:- supporting services to deliver excellent care every day; meeting our regulatory requirements; supporting quality and service improvement; horizon scanning and intelligence.

A key part of the Trust's human resources strategy is Investors in People (IiP) with the Trust aiming for gold standard accreditation by June 2012. IiP is a performance improvement tool focussing on people management and leadership which promotes best practice. A very positive internal review July/August 2010 suggests we are on our way towards achieving accreditation.

**Trust staff involved in developing the use of information technology**

Members of the RiO (clinical information system) medics group are positively working to enable RiO to support and improve practice whilst also ensuring that required organisational reporting is met. One particular initiative has been the development of an 'in-patient discharge note' enabling timely provision of discharge summaries to GPs and a letter to the GP following an appointment that also acts as a care plan for the service user. Medical staff and administrative support workers are changing the way that they manage the letters and have incorporated Care Programme Approach information recording in the process. The group also developed a process to capture required service user employment and accommodation data.

**Using communication processes to their greatest effect.**

Twitter is an innovative way to encourage local people, staff, members and stakeholders to keep up to date with the Trust and mental health news. 'Followers' hear the Trust's latest news helping us publicly strengthen existing stakeholder bonds and make new ones. In August 2010 the Trust was ranked the top mental health Trust in a national NHS Twitter league table and tenth out of all NHS organisations currently tweeting.

The members magazine 'Like Minds' showcases the Trust's work. 14,000 people receive the magazine. As one member commented *'Like Minds is absolutely excellent. The quality of information, comment and advice is comprehensive in its range and grasp of issues. It is a credit to all contributors and production staff. I had an emotional response when reading it and I cannot praise it too highly. Well done!'*

The easy to read Care Programme Approach (CPA) Information Booklet is aimed at those who use services and their carers. Produced through a process of engagement with service users the feedback from both service users and staff has been extremely positive.

**Sustainability - small changes can make a positive difference.**

A Trust website section gives new starters access to all policies before entering the workplace. An online declaration form confirms they have made themselves aware of key policies details of which are automatically logged allowing checking that this requirement has been fulfilled. Previously about 30 new starter packs a month were printed, packaged and sent with postal costs of £1.32 per pack. Now the price is 41p. The new starter website has freed up recruitment team time to focus on other duties and reduced waste. There has also been very positive feedback from new starters using the easy system.

**Different communities can face exclusion from employment opportunities.**

People from South Asian communities are accessing training and NHS employee experience. Traineeships lead to nationally recognised qualifications (NVQ 2 and technical certificate) and 4 out of 5 trainees from 2010/11 now hold substantive posts in the Trust. Positive external evaluation by Huddersfield University highlighted that trainees value the experience, gain personal satisfaction, cultivate a positive work ethic and develop transferable skills. Teams working with the trainees felt the benefits of the scheme included making their working lives easier. '*The scheme has given me valuable experience and the opportunity to work and support individuals within the South Asian community ... I can communicate with ... and be empathetic to their culture and beliefs ...''*

**Individual skill, expertise and caring make a difference**

After completing the Trust's 10 day Psychosocial Interventions (PSI) course a practitioner integrated theory into practice with a gentleman detained under the Mental Health Act. The gentleman was alienated from services with many staff intimidated and feeling that it was unlikely that he would successfully return home. The practitioner recognised that recovery was underpinned by the values of hope, acceptance and empowerment and explored ways of developing these within the therapeutic relationship. As a result the service user has successfully returned home and continues to grow in confidence.

## 1.4.2 Experience

Service users' experience of the services provided is constantly evaluated and ways to improve the experience sought.

**We want to promote involvement in service developments and decisions about care – listening and learning from service user surveys, feedback and complaints is very important.**

The equality & inclusion team organised workshops for service users, carers and staff to help develop the new involving people strategy. Comments helped shape the Trust's Charter for involving people (especially reaching out to people whose voices are seldom heard) and informed the strategy action plan. One partner organisation 'Kirklees Voice' commented ' *I have always found that the Trust tries to engage with service users/carers in mutual dialogue to help improve services for people with mental health conditions and their carers … I am pleased that comments made by service users and carers at the workshops have helped shape the Trust's charter for involving people and has given us an action plan that we can work with in the future. People that attended the workshop found that it gave them a chance to influence the future of services by giving them a voice'*

The 'United Minds' low secure service users group is chaired by a service user and meets monthly. The group has promoted many positive quality of life changes such as barbeques, day trips, ordinary crockery used at meal times and gardening projects. An issue regularly raised by members of the group is the quality and choice of the meals available and the group have worked with managers and the facilities department to make improvements.

The Trust participated in both the national Care Quality Commission community patient survey and a 2010 in-patient survey involving 33 Trusts nationally where we were above the benchmark average for 61% of the questions. The Trust also conducts local discharge surveys which over time have shown generally good and improving results across most areas e.g. the 2009/10 report identified over 80% of service users had received clear information on admission, felt they could ask about medication and side effects, felt they had benefited by the care received, felt safe and secure in hospital, felt they were listened to effectively and their opinion valued by nurses. The adult survey was extended to older people wards in 2010/11 and informed a Commissioning for Quality and Innovation (CQUIN) requirement. The Trust achieved all 5 of the patient experience CQUIN criteria set by our commissioners. The discharge survey also informs our own service user experience Key Performance Indicator – across the year the percentage of those who returned questionnaires rating care as excellent, very good, or good has remained consistently above 85%. The Trust's forward strategy is the acquisition and implementation of real time patient feedback kiosks on all our ward/clinic areas.

95% of complaints should be responded to and action plans developed within negotiated timescales and there have not been any instances of non-compliance with policy or NHS regulations. All complaints are dealt with as speedily as possible, timescales negotiated and each person offered regular updates on progress until issues are resolved to their satisfaction. Examples of practice improvements implemented following service user feedback include: environmental improvements such as installation of additional heating in a ward hallway; introduction of leadership behaviour and protocol sessions with clinical team leads, ward, service and general managers; review of food quality, with the involvement of a service user group, including the introduction of cooking groups; change in use of ward accommodation to create a visitor lounge; and, establishment of a gardening group to enhance an outside area

**Meeting the spiritual and cultural needs of our service users and their carers is extremely important.**

The new medium secure unit multi faith room offers a tranquil space in a very central location and is used extensively by both service users and staff for a variety of activities including meditation, prayer and religious services. Service users led on planning and design of the facility with involvement throughout including the production of artwork such as the much admired painted perspex window panels. A large natural piece of rock as the centrepiece is seen as a unifying symbol which transcends all differences of culture, ethnicity and religion as well as being a very beautiful object and a focus for reflection. The development has set a benchmark for the Trust with a number of other multi-faith facilities being planned or completed in other clinical areas. As one staff member commented *'It is hard to overestimate the value of this project. It not only provides a much needed aesthetically pleasing tranquil space for patients and staff but also because of its inclusivity it is a powerful symbol and agent of unity for service users from widely different cultural and religious backgrounds.'*

**The Trust wants to do all it can to help reduce stigma and raise awareness.**

The Young Peoples Schools Project (YPSP) aims to reduce stigma and raise awareness of mental health issues with young people (aged 11-19). Adaptable sessions consist of activities such as a quiz to prompt discussion about celebrities and their experience of various mental illnesses, DVDs to explore the effects of mental illness on people's lives, group discussions on wellbeing and mental health. There is a high demand for this work from schools and we are looking into developing 'train the trainer' packs so that schools can deliver some of the sessions themselves. YPSP has evaluated well and whilst sometimes challenging, the sessions have been successful. *'As a School Governor, I was impressed with the thought, effort and quality of the two 1 hour sessions this team put into this pilot programme. The students were interested and thought the presentations hit the mark in trying to make them think about mental health problems and their effects'.*

**The Care Programme Approach (CPA) is fundamental to effective care delivery.**

- In 2010/11 a new CPA Policy was approved by all partners (Trust and three Local Authorities) and a joint CPA workshop involving staff, service users and carers was facilitated by Simon Duffy, Director of the Centre for Welfare Reform. The Trust has approved a new health and social care assessment and is committed to the implementation of the recovery star (an evidence-based tool which measures the impact of services and interventions) to underpin effective assessment and care/support planning.
- Throughout 2010/11 the percentage of people recorded as being given or offered a copy of their care plan has remained above 80%. Work is continuing on the development of a care and support plan (to be co-produced by the care co-ordinator and service user) designed to reflect the domains of the recovery star and the health & social care assessment.
- Actions taken following the 2009/10 Trust-wide CPA audit have included capturing carer assessment requirements, advanced statements and advanced decisions on the electronic record. A CPA work based competency document for care co-ordinators to use in supervision plus an information booklet for service users and carers have been developed. A rolling training programme includes: service user /carer engagement within CPA processes and understanding co-production; documentation and reporting; and personalisation. As well as a vehicle for identifying and improving practice, the CPA audit also addresses: contractual requirements; some aspects linked to CQUIN targets; and, provision of evidence to demonstrate progress against certain recommendations/actions in relation to independent inquiry and serious untoward incident reviews.
- Improved areas in the latest 2010/11 CPA audit results include: the provision of information; service users and carers having access to care plans and being engaged in the care planning process; service users and carers being engaged in assessment and review processes.

**The Trust continues to take an active role at promoting inclusivity.**

A learning disabilities World Cup day at an indoor football venue in Kirklees officially presided over by the Mayor of Kirklees involved people with a range of disabilities including those with complex physical needs who are often isolated from competitive team sports. Planning in partnership with football professionals and university students (linked in with PCTs, local authorities, health safety site visits) a range of inclusive football activities, competitions and games was developed. A realistic full scale model of the world cup and commemorative medallions for all participants were procured. Extremely positive evaluation results (including participant responses) helped underpin planning for a series of similarly styled forthcoming events with a view to turning ideas into a sustainable venture working in partnership with a range of organisations. ' *Dear N, On behalf of the users and staff at XXX Day Services we would like to say thank you for an enjoyable day at the learning disability World Cup day. The activities that were provided were entertaining and fun. We would also like to thank you for making the day Wheelchair friendly as the users were smiling throughout the day. We hope there will be another one soon. Many thanks again.'*

The multi-professional and cross-organisational Extra Mile Team helps people with learning disabilities who have difficulty accessing hospital services. Coordinators are the central point of contact for all agencies, family and the service user. They work with the service user and their family to understand what reasonable adjustments are needed to existing pathways to access treatment successfully, safely and to make the experience tolerable such as: pre assessing patients at their home or day placements, opening theatres and having theatre teams for individual patients, family members supporting in theatres, multiple procedures happening at the same time. Several people with varying degrees of learning disability, complex health care needs and challenging behaviour have now successfully followed their person centred pathways through the hospital system and accessed treatment. *'I was very pleased with the outcome for my son and the amount of detailed planning that took place to make the surgery happen. We were involved and listened to and all went to plan on the day.'*

An adult ward in Kirklees exhibited service users' art, sculpture, creative writing and photography in partnership with a local library and art gallery. Service users gained therapeutic benefits from organising the exhibition which was open to the general public for 3 weeks, promoting mental health in a positive manner and celebrating service users' talents. A preview night was organised to let service users see their work on display, as well as allowing their family and friends to witness their achievements. The project has allowed links to be developed with West Yorkshire playhouse and opened up the opportunity to display in their building. A project has been initiated at a Sure Start children's centre and library which will include creating art work for the centre. *'It makes me feel worth living when I can still create something that someone can enjoy. It makes me feel like I have a purpose and a point. We all know that creative work can be relaxing and a way to express yourself and more than 1 person can say. It gives me a purpose.'*

A low secure centre ward has focused on developing service user skills and interests prior to discharge. One project has been to develop a small garden within the internal courtyard, a bigger planned project is the development of a vegetable plot.

The medium secure service user group wanted to develop a summer musical festival event called Lodgefest. Joint planning between service users and staff made it a day to remember with a large number of stalls, activities (including a bungee run, sumo wrestling, tug-o-war, touch rugby, goal scoring, race nights) and musical events. One senior manager said the event was a great success and credit to all involved. Another staff member commented that *"It was a brilliant day and everyone had a great time getting involved in the different activities. It was an opportunity for staff to relax with patients and for patients to forget their troubles and get lost in a day of fun. We know that creativity, physical activity and social inclusion all make a big difference to wellbeing so Lodgefest focused on these areas."*

**Good mental health and vocational opportunities are promoted through partnership.**

The recovery through reading partnership (Wakefield day treatment service and Wakefield library service) is a reading-based group for adults with anxiety, depression and other mental health issues. Library staff visit the service to enable participants to join the library, providing a list of multiple-copy books, and, once the group select a book, ensuring copies are available in each participant's chosen library. Accessing the books in this way is crucial for participants with anxiety, enabling them to achieve functional goals through a graded exposure programme. As the group developed (following evaluation and feedback from group members), the partnership has grown with library staff now involved as group coordinators and final sessions held on library premises, to facilitate a transition to library-based reading groups. Using Rosenberg's Self-Esteem Scale (1965) there has been a demonstrable significant improvement in self-esteem for each participant. '*I found the reading group highly enjoyable and constructive. It was great to be in a relaxed environment where a diverse group of people exchanged thoughts and opinions on a range of literature. It was a lovely confidence builder and a good way of achieving goals around communication'*

Refresh vocational services social enterprise for adults in Calderdale who have experienced mental health problems comprises a cafe and workshop offering training and work experience in a supportive, realistic work environment. The workshop provides a furniture re-upholstery service also making furniture and items for use in the café. The wall space offers local artists, some of whom use mental health services, a place to exhibit and sell their work. Trainees learn new skills and build confidence, whilst working on a structured training programme and are then supported to move on through organisations such as Voluntary Action Calderdale, Job Centre Plus, WorkWise, A4E Pathways, Calderdale College and Adult Education. Volunteers are provided with an enjoyable environment to use their skills and talents to benefit the project and the community. The general public have access to a relaxing and welcoming cafe, with a strong community focus and opportunities to get involved. Refresh has received positive feedback from referees and trainees who have spoken to the local press about their experience. Refresh has become a place where mental health services and the community mesh together and is a real working example of the shift from segregation to inclusion. *'When you have a mental illness, it is difficult to get back into work. I feel as though I am doing something valuable for myself and others. Refresh just gives people the chance to start again and to make a real difference to their lives.'*

**Directly supporting carers is another critical area.**

Learning disability - mutual respect carers group has given carers an opportunity to let the assessment and treatment service know what was and wasn't working well from their perspective. Carers' surveys helped gain views on different service user journeys and a carer workshop was organised. The carers commented that they thought it was very positive of the Trust to listen to them about their experiences and requested feedback about how their comments and suggestions had been acted upon. '*The carer group was really useful in highlighting positive practice and areas for change and has allowed the service to make significant changes around developing positive patient experience. It also challenged some of the presumptions we make as professionals about what is right for the service users'.*

An older people community mental health team carer support group consists of people who have become experts in their own right by caring for people with various illnesses; Alzheimer's, anxieties, psychoses, each with a shared vision to offer the best care they can to their loved one. The carers gather together to share their experiences and information with each other, offering even further support for people who have become friends through circumstance. *'Help and advice … that has seen me through some very difficult times. They have advised me and informed me on other things I knew nothing about. I know I have only to phone for help and they oblige'*

**Many benefits are achieved via a variety of groups and activities to promote positive mental and physical health.**

One therapy team has introduced Nordic walking sessions - walking with poles similar to ski poles to work both the upper and lower body at the same time burning more calories than regular walking whilst improving general health and wellbeing

A medium secure woodworking group provides people with the opportunity to learn basic but transferable woodworking skills with future plans to offer a structured training programme for service users to obtain a recognised carpentry qualification '*Attending woodwork sessions with X have been highly beneficial to me as it has helped brush up my skills and also helped me with my motivation, keeping me on the move both mentally and physically'*

2 medium secure service users gained a 'Level 1 Award in food safety awareness in catering' certificate via 'cooking for life' sessions. *'The course was well co-ordinated and managed. The sessions were interesting and you could choose if you wanted to take an exam or not. I did, it helps you for when you move into the community. You get a certificate that is recognised outside hospital'*

Early intervention in psychosis services offer various social inclusion activities to provide service users with increased structure to their lives and improve confidence and self-esteem. Activities have included: guitar jamming, an afternoon of arts, monthly social groups for organised sporting tournaments, beauty therapy sessions, theme park visits. 7 service users went to Wales to complete outdoor activity pursuits challenges which had a clear outcome of increased confidence and ability to communicate and problem solve. Another 7 service users had a trip to GO APE to promote social inclusion, break down stigma and support service users to face their anxieties. '*Art Group at Insight is a really good group. It has given me the opportunity to come and meet new people and make friends and also taught me healthy ways to express my thoughts and feelings through art. It is a safe and comfortable environment to come to without the pressures to pretend I'm happy all the time as there is in other environments such as college. The staff are friendly and approachable and it's a great group to be involved with. It's great to go and have a coffee and talk to other people of different ages and from different backgrounds as well as doing something I love - art!'*

One in-patient ward activities team has expanded their activities programme through external partnerships such as the creation of a weekly drama workshop to provide an outlet for self-expression, artistic awareness, social awareness and self confidence. The West Yorkshire Play House have provided backstage tours of the theatre and discounted theatre seats. There have been links with performers who have run workshops on the ward including a published poet and author, an Emmerdale actress, a story teller, clog dancer and ukulele player. '*As a member of ward staff I find the activity team a valuable tool in helping to fulfil the therapeutic needs of our service users. Boredom is a major issue of our service users on the ward. Activities workers facilitate a number of different groups and activities to alleviate this. The activities team promote community services and aid in the referral process so that service users can access community activities after discharge.'*

An older peoples community mental health team offers several groups to encourage service users to partake in socially stimulating activities, such as a cinema group, walking groups, dementia dance movement and music classes, and creation of Life Story books.

A learning disability patient experience group developed a full day learning disability awareness session with one key theme being 'This is My Life - Aspirations of a person with learning disabilities'. Service users and carers share their real experiences and course participants relate these to every day work situations. Evaluation shows that messages delivered by carers and service users are hard hitting but well received.

A 2 year learning disability 'Cook and Taste' project let service users taste and enjoy new dishes they would not normally have eaten and different fruit and vegetables. Service users felt that they had gained in confidence to remake some of the dishes at home and suggest alterations to recipes used. '*Staff were very nice, helpful and they all had lots of fun doing this course and wish that other service users had the opportunity to do it too.'*

**Effective communication with service users and carers can be vital in ensuring service users' experience of services is a positive one.**

In 2010/11 there has been the successful transition of services off a main hospital site in Huddersfield. In order to ensure a smooth transition a monthly focus group was established involving service users, carers, third sector staff and the members council to keep people informed and find mutual solutions to any issues. There was a monthly St Luke's newsletter and an open day attended by nearly 100 people at Huddersfield Town Hall to give the public an opportunity to learn about the project and talk to staff involved in the different workstreams. Other communication processes included website information about the project, information displays and comments boxes in hospital foyers. Carers and service users were recruited to be involved in workstreams of personal interest to themselves. Service users and carers were also invited to attend the regular events set up to brief and update staff.

Effective communication is key in providing quality services in learning disability services which has the added challenge of addressing communication difficulties experienced by each individual. The speech & language team have presented and implemented a number of innovative ideas that have benefited service users to have more meaningful involvement and inclusion in their care and ultimately provide a person centred approach. One example is mutual respect interviews - held with service users to ascertain their experience whilst on the inpatient unit ensuring appropriate means of communication are used in reference to the individual's abilities such as use of symbols, objects, visual prompts and physical cues. Service users choose the time and place of the interviews and the person conducting the interview sat outside of the team delivering the individual's care. A lot of positive practice was highlighted but a number of areas for improvement were identified which challenge assumptions made by clinicians about what is right for the service user e.g. times of boredom on the unit.

A medicines information event in June 2010 involved local people who use services and their carers. A number of guest speakers included the Trust's medical director and chief pharmacist and sessions were held on factors influencing decisions to take medicines or not and medicines choice. Workshops were run to gain feedback on information leaflets, how to ask about medicines, become involved in medicines choice and ask questions relating to the Trust's policy on prescribing medicines. A small group has been established tasked with taking most of the suggestions forward. *'Service users attending the day gave us some really useful and positive feedback to help us direct future work. Service users, carers and professionals alike got a great deal from the day'*

Frontline is a high-quality popular mental health magazine with a distribution of at least 1,000 copies per edition. The magazine is unique in that service users not only play a key role, but are the driving force behind its day-to-day running. The chief editor is a service user as are the main, regular contributors and the graphics designer. Some staff are involved in an advisory role but editorial control remains with the Service Users. Contributing service users are encouraged to tell their stories and share their experiences. Frontline has been widely praised for its interviews, reports, photography, graphic design and readiness to include difficult and challenging mental health issues such as suicide and the experience of being detained under the Mental Health Act. *'The great thing about Frontline is that it is genuinely service users who run it, from the design, photos, articles to the publicity. The quality of the magazine is always exceptional. The other thing I like about Frontline is that they do not shy away from exploring controversial issues.'*

Calderdale inclusion support service - a partnership between SWYPFT and Calderdale Council providing a service for adults with mental health issues across the Calderdale district - produce 'The Vibe' as the service mouthpiece. The Vibe is a small, handy sized magazine packed with information to pass on to service users and the wider community. People have commented that they find the magazine enjoyable, illuminating, informative and put together in a professional but approachable and friendly format. About 1,000 printed copies are distributed across Calderdale, including in GP Surgeries, Libraries and many other public places. There is also wide distribution of email versions. *'Vibe magazine is unlike many other magazines-covering a wide variety of subjects in one nifty publication. It is informative and thought provoking without being preachy or judgemental. Over all a fantastic read and one that I have, on many occasions, recommended to both friends and library users.'*

**Service users gain most benefit from care provided in environmentally appropriate facilities.**

Newhaven is a 16 bedded regional low secure rehabilitation service which has undergone extensive service re-provision and relocation from Huddersfield to Wakefield. The regional commissioning team sought to commission a service which was modern, forward thinking, and a centre of excellence for the provision of learning disability services to service users requiring low secure care. The central strength of the planning process was the active participation of service users in developing the service specification for what would be their home. Service users were involved in all aspects from identifying bedroom areas for the new build, choosing colour schemes, carpets, and types of furniture. A service user group enabled service users to come and view the new build once every fortnight; in the process they were supported in making a video diary of the progress. Service users were also actively involved in the recruitment and selection process of new staff and involved in producing art work published in the Yorkshire and the Humber specialised commissioning group publication 'Making Progress' - A Strategic Vision for Low Secure Services 2010/11 to 2014/15.' Our transition from Huddersfield to Wakefield was hailed as a success and we have successfully moved with our service users into a well resourced service.

The Trust complies with Eliminating Mixed Sex Accommodation (EMSA) legislation with no reported breaches in year. We also monitor whether service users are ever placed in an individual room on a corridor occupied by members of the opposite sex. The Trust has developed an EMSA quarterly review group chaired by the assistant director of nursing with the remit to review any incidents and raise these with the relevant director for action. Compliance with the EMSA agenda is reported on a quarterly basis to the clinical governance and clinical safety committee.

**End of life care provision should offer sensitivity and dignity**

A recovery unit for older people developed from the reprovision of an old hospital facility has a number of people previously placed on the unit as a 'bed for life'. As these people become older they inevitably approach the end of their life. During the late end of life stages for one service user staff worked with the person and their family with dignity and sensitivity. This work was commended by a palliative nurse specialist. *'High standards of care have been commended at XX, a unit for older people with mental health problems. The team were praised, in writing, by a clinical nurse specialist from another organisation who commended the team's high standard of care to a service user and their family as well as excellent cross-sector working'*

## 1.4.3 Safety

### NHS Litigation Authority risk management standards

The Trust retained Level 1 during an assessment in December 2010 achieving a score of 47 out of 50. Level 1 shows the Trust can demonstrate that it has approved documents that meet a range of minimum requirements.

### Infection prevention and control (IP&C)

- The Trust has remained compliant with the Health & Social Care Act (DH 2008): Code of Practice for health and adult social care on the prevention and control of infections and related guidance throughout 2010/11.
- There have been no MRSA bacteraemia or clostridium difficile cases reported in 2010/11. Although there have been 5 occasions when we closed units due to an outbreak of either confirmed or suspected Norovirus all outbreak reports indicate that staff acted promptly to minimise the risk of further infection. Outbreak toolkits for diarrhoea & vomiting and influenza continue to enable swift and effective action to be taken to minimise risk. The annual winter bugs awareness initiative has been rolled out to maintain a high risk profile throughout the Trust.
- Training and development has included: Level 2 City & Guilds Award in infection prevention and control successfully completed by the first cohort of 6 students. The Trust is one of the first in the country to do this. IP&C mandatory training has been introduced formally into the Trust's corporate induction programme as well as ongoing mandatory IP&C training tailored to the needs of different staff groups and e-learning. In 2010/11 947 people received IP&C training.
- An interactive IP&C learning pack designed to teach both staff and service users has been developed and piloted. This pack raises awareness from a service user's perspective that infection control is everybody's responsibility. The IP&C team have accompanied community staff to work with service users in their own homes. This new venture has enabled the team to reach difficult to engage people and offer support/advice as part of their ongoing care.
- The IP&C clinical audit programme was completed with action plans implemented on all 30 units audited to ensure continued improvement against standards of cleanliness and clinical practice. Internal PEAT visits (with service users as PEAT members) during the year demonstrated good standards with no major hot spots identified.
- Partnership working: the seventh Vital Link study day was held in November. 87 staff attended from the Trust, NHS Wakefield, Mid Yorkshire Hospitals Trust and the Health Protection Agency.
- Risk Management: In complex cases specialist advice and support has been provided by the IP&C team, management of aggression and violence team and specialist advisor for vulnerable adults with appropriate input into the service user's care planning process.
- In 2010/11 there were 34 reported IP&C incidents. Although the overall number of incidents increased by two from 2009/10, all incidents were rated either green (29) or yellow (5). In 2009/10 the figures included 3 amber rated incidents.

### Falls Prevention

The Trust has a falls strategy and a multi professional falls network in situ and continues to partake in national falls work such as the Royal College of Physicians falls and bone density audit and presenting at the 2010 national falls conference in Manchester. The re-fitment and expansion of an older peoples ward allowed the trust to modernise and use the latest sensor technology in each of the 30 bedrooms. The sensors are versatile and are specifically designed to, if need be, monitor the patients movement around the room 24 hours a day. (The Trust has met the CQUIN falls target set by the commissioning PCTs in 2010/11).

## Safeguarding Children

- All required Section 11 Audits have been appropriately completed and submitted to the 3 Local Safeguarding Children Boards (LSCBs). There was a challenge event in Kirklees when the trust's named nurse provided evidence and was questioned on the Trust's S11 audit submission by a panel of Safeguarding Board members. Formal feedback received from Kirklees LSCB states: *"This years Section 11 Challenge event once again highlighted the commitment of your staff to ensure safeguarding is of the highest quality for children and young people within Kirklees. We would like to express our gratitude for all the hard work that goes into the audit process by members of your staff team."*
- Level 1 staff training has been maintained at 100% and there is a rolling 3 year training programme for level 2 training.
- In 2010/11 the Wakefield Area had a planned OFSTED inspection. The health and social care community received the official report in February 2011 which indicated overall effectiveness of safeguarding services as adequate. Recommendations have been made and action plans submitted.

## Safeguarding Vulnerable Adults

- The Trust provides safeguarding adults abuse awareness training for all staff with the aim being that all Trust clinical staff access level 1. Training has also been provided for partner agencies such as staff in joint teams and the police.
- The Trust has translated its Domestic Abuse Guidance into formal policy which includes risk assessment and multi agency referral process for serious cases to be taken forward to Multi Agency Risk Assessment Conference (MARAC) meetings.

## Managing and learning from Serious Incidents (SIs)

- Effective incident reporting and management is an essential component of a safety culture. The Trust's new web-based incident reporting system enables rapid real-time incident reporting and communication, which supports the effective management of SIs. Reporting and performance management of SIs was transferred from the SHA to the commissioning PCTs in June 2010.
- An incident review sub-committee (of the clinical governance and clinical safety committee) has been established to bring additional rigour to the SI investigation, reporting and learning process. All SIs are now reported to the sub-comittee and a system is in place for the review of all SI investigation reports, recommendations and learning. All reported SIs have been investigated by the Trust and where recommendations for improvement were made an action plan developed to address these and support learning from experience.

## Information governance (IG)

- Information Governance is a broad ranging term which covers the security and integrity of all the Trust's information. The Trust is assessed against the 45 standards within the information governance toolkit. 2 submissions to Connecting for Health were required in 2010/11 – a baseline position in October and end of year submission at 31st March. The operating framework for 2010/11 states that all standards must reach level 2 by March 2011. Trusts failing to reach level 2 on any of the standards will be closely scrutinised and required to submit action plans. The Trust has progressed a great deal of work throughout the year to try and achieve level 2 on all standards.
- The information governance trust action group has met 7 times in 2010/11 in addition to holding a half day workshop and has reviewed information technology security, data quality, incidents and complaints and risks relating to information governance. Information risk management has been underpinned by information asset owners and administrators identified to support the Trust's senior information risk owner. Risk assessments are carried out annually.
- The number of Caldicott queries raised by staff has decreased whilst the number of reported IG incidents has increased which may indicate increased maturity of understanding.
- The IG Toolkit has introduced a much wider requirement for information sharing agreements where service user information is shared with 3rd parties for direct care. Work progressed in-year has included the identification of all partner organisations and will include sign up to information sharing agreements. This work will continue into 2011/12. An audit of information sharing arrangements has been carried out and a staff leaflet informing staff of their responsibilities has been distributed with payslips.
- Work has commenced on reviewing the older records held in the Trust off-site store, with a view to ensuring compliance with the NHS code of practice on records management and reducing storage costs to the Trust.

## Electroconvulsive Therapy (ECT)

The accredited service is guided by NICE, Royal College of Anaesthetists, Royal College of Psychiatrists, ECTAS (ECT accreditation service) national standards for clinics, Mental Health and Mental Capacity Acts. In June 2010 ECTAS Royal College assessors undertook peer audit of our practice, documentation and protocols reporting *"They have continued to maintain high standards and the quality of documentation and team working remains outstanding. There is an excellent system of keeping monitoring of patients, throughout treatment, in-house".* ECT doesn't carry the same degree of risks as performing invasive surgery, however, there are a number of issues associated with the treatment that we felt that a more robust checking process would improve patient safety and treatment outcomes. Although not a legal requirement for ECT Units, we proactively adapted the World Health Organisation surgical checklist (to promote effective communication between different disciplines, ensure basic minimum safety standards and reduce errors) to suit our practice, using the 3 identified stages that are carried out before, during, and post each individual's treatment session. Implementation of the checklist has made efficient use of time and had a significant effect of providing better outcomes for service users at no extra cost to the service. The processes introduced include: a pre treatment meeting prior to every session with a meeting record - who was present, and who had checked the equipment prior to using it; further checks prior to treatment - confirmation of patient identity, allergies, laterality and dose incorporating a signature recording these checks on the treatment record booklet; end of the treatment and recovery completion of final checklists – recording that the whole procedure has been completed and that any equipment or recovery problems that may have arisen during the session have been documented and addressed. The process is supported by an A3 laminated poster that easily identifies the checks that are required, and at what stage of the treatment they should be carried out and acts as a clear and visible aid for all treating practitioners to see. The recent Royal College peer review praised the checklist as *"an advanced document regarding WHO assessment"* and recommended national presentation of the work.

## Medicines management

- The Trust has an accountable officer for controlled drugs who has remained in post over the last 4 years. The accountable officer regularly attends the local intelligence network and shares incidents where appropriate. The number of incidents has reduced from 2009/10 with only 45 against 66 for the same period in 2009. Incidents relate to safe storage, administration and prescribing. The incidents are monitored for themes. The Trust has a full set of controlled drugs procedures which are monitored regularly with safe storage requirements regularly checked by the pharmacy and nursing team
- Service users in North Kirklees prescribed Clozapine now attend a Clozapine Clinic - each person having a 15 minute appointment where their blood pressure, pulse & temperature are taken and a list of side effects monitored & discussed. They also have a Glucose test every 3 months, a yearly Plasma test and a regular ECG arranged by the doctor. The clinic runs alongside an outpatient clinic enabling better liaison and immediately highlighting any concerns or significant changes in patients' physical and mental health.
- A user friendly easily accessible nurse led lithium service (older people) in Wakefield initiated in 2009 promotes engagement and subsequent appropriate mental / physical health monitoring. Previously individuals would be seen by medical staff within an outpatient setting and physical health monitoring would be carried out by their GP. If individuals didn't attend clinic or their GP surgery they were at risk of missing follow up and subsequent deterioration to mental and physical health. Anyone unable to get to the clinics is visited at home. *'I know I need to take lithium and have worried about its effects but now am confident that if anything was wrong it would be found quickly and also the nurse are so welcoming I can tell them anything and they won't judge me but will try to help'*
- The multi-disciplinary Safe Medicines Practice Group (SMPG) - including pharmacists, pharmacy technicians, community nursing staff, ward managers and crisis teams – reviews reported incidents looking at common themes, medications and systems involved in reports. The objective is to ensure that learning from medicines related incidents is clearly identified and related back into clinical practice. The group addresses issues with a view to reducing incidents and near misses both within the Trust and reported via the Medicines Health Regulatory Agency. The group develops safe medicines practice alerts and also reviews National Patient Safety (NPSA) rapid response alerts on behalf of the Trust assisting in meeting the care quality commission standards and improving quality of care for patients.
- Anti psychotic medication reviews in Care Homes in North Kirklees are undertaken by the visiting doctor and support worker. They review individual care plans, assess the client's current presentation and needs and review anti-psychotic medication in line with NICE guidelines. If there is evidence of settled behaviour or other related dementia presentation that would not respond to medication, the medication is titrated down and stopped if possible over a period of months so reducing potential risks of unwanted side effects such as over sedation, increased risk of stroke and minimising risk of falls. An audit demonstrated a saving of over £31,584 in one year (£2,632 per month) in reducing non-required antipsychotic medication. As a result of the medication reviews, there have been no admissions to in-patient services. This work was shared regionally through the innovation for dementia directory YHIP and also with Alistair Burns national clinical director for dementia who expressed the view that *'This is powerful stuff'*

## Medical Equipment

Although we do not routinely use equipment such as pulse oximeters and oxygen the Trust must comply with a number of external compliance initiatives relating to patient safety, anoxia and the use of oxygen and medical air. Oxygen safety issues form the basis of a rapid response alert from the Patient Safety Agency. Action taken has included air cylinders withdrawn from inpatient areas and replaced with electric nebulisers reducing the risk of giving air instead of oxygen, or vice versa. All emergency oxygen provision on the wards is now delivered by small, easily portable cylinders stored in a distinctive bag, along with the pulse oximeter where needed. Training in the use of this equipment is provided in clinical areas by the physiotherapy team who provide input and advice to any area that has a service user on prescribed oxygen. Update training in the use of emergency oxygen has been incorporated into the mandatory resuscitation training provided in the Trust. As one Trust Board member commented *'I was very pleased to see the outcome of this action during the clinical governance assurance day held on the 7th July. This enables a clinician to respond in a fast and flexible manner to an emergency situation with the most up to date oxygen provision. The equipment is very simple to use and also very lightweight which is very important in an emergency situation. It has also demonstrated how professionals from different backgrounds work together to produce a very good outcome of quality clinical care'.*

## Risk Assessment/Suicide Prevention.

- A lecturer practitioner (Forensic Services) led a team who have developed a tool for assessing which clients are at a risk of committing suicide or self harm. A screening tool can be quickly used on admission or assessment and then if necessary a full suicide risk assessment tool is used. The tool is now used on all medium secure unit wards. Feedback has been positive about the tool helping inform clinical judgement.
- The Trust and partner Primary Care Trusts form a local suicide prevention network via which there is consideration of national and local best practice and audit findings are shared and reviewed. A network event held in November 2010 involved the local coroners and a guest presentation by Dr Zaffer Iqbal – a founding member of the team responsible for pioneering early intervention in psychosis in the UK.

## 1.4.4 Challenges

Some of the key challenges we have faced in 2010/11 have been:

**Serious Incidents (SIs)**

South West Yorkshire Partnership Foundation NHS Trust makes every effort to minimise risk and prevent serious incidents from occurring. However when incidents do occur they are always rigorously investigated and lessons learned.

- There has been a total of 26 Serious Incidents in 2010/11. (There were 28 in 2009/10).
- One 'Never Event' occurred in the Trust involving a service user absconding from the medium secure unit. The person was safely returned within a few hours, however this incident met the NPSA Never Events criteria: *'escape from within the secure perimeter of medium secure mental health service by patients who are transferred prisoners'*. A thorough review was undertaken and systems assurance given.
- There have been 4 SIs involving the suicide or suspected suicide of inpatient service users; each of the 4 cases occurred on a different unit, and none met the criteria of a 'Never Event'. All have been thoroughly reviewed individually by the Trust and action plans developed to address the recommendations and learning. Following completion of the 4th case review a further review of all 4 cases by an external investigator has been commissioned, to bring additional rigour to the process and identify any additional concerns or common factors. Two of these deaths actually occurred on the ward, one occurred while the person was on leave and one following the person absconding from a ward. Following the absconding incident a new system was installed to the unit doors. The unit is now accessed via a video entry system operated from the main reception for visitors and by fob system by the staff. The inner door will only open when the outside doors are in the closed position and vice versa creating an air lock. Further security measures have been put in place including changing all the outside door locks minimising the number of people who can access the unit without coming through the main reception.
- An inquest involving the death of a service user previously in the medium secure unit took place in June 2010. The findings from the inquest were that the person died as a consequence of an injury sustained in 2008 whilst being appropriately restrained following an incident of aggression whilst detained under the Mental Health Act. The Health and Safety Executive (HSE) conducted a visit to the Trust on the 15.07.09 to review this SI. Following the inquest the HSE asked the Trust for clarification of some systems and processes, and that the Trust responded to the HSE in writing.
- Three Independent Inquiries relating to SIs involving homicide by service users, which occurred in 2007 and 2008 were commissioned by the SHA and NHS Kirklees in September 2010. These reviews come under HSG 94/27 – Independent Investigations of Adverse Events in Mental Health Services. These are currently being undertaken by the Health and Social Care Advisory Service (HASCAS) with an anticipated report date of May/June 2011.

**Managing Aggression and Violence (MAV)**

- The Trust's MAV team members are all specialists and offer advice, support and training to teams, services and units Trust-wide.
- In 2010/11 there were 838 reported incidents of physical violence against staff by a service user and 319 incidents of physical violence against service users by another service user.
- The overall number of incidents in both categories fell above the anticipated number based on numbers from previous years by 2 incidents. Of the total incidents none were graded red, 18 were graded amber and the rest were yellow or green. Incident rates are higher on certain units such as the Psychiatric Intensive Care Unit where there are people with very challenging behaviours and the MAV team work more intensively with units experiencing increased incidents. Particular service users can account for multiple incidents e.g. one service user was responsible for 18 of the recorded 24 incidents in one month. In cases such as these specialist advice and support is provided by the MAV team and other specialist advisors with appropriate input into the service user's care planning process.
- Staff on in-patient units require a 5 day MAV teamwork course (4 days in older people services). Currently 75.4% of staff are trained in physical interventions across inpatient units. These staff require a 2 day annual update with staff who do not attend an update within 18 months being required to retake the initial course. The training programme for non-clinical staff is to be enhanced by the introduction of an e-learning package developed in conjunction with the Strategic Health Authority

**Legal Claims**

There have been a total of 22 registered legal claims received in 2010/11. The activity relating to claims does not necessarily relate to incidents that have occurred during the same period and the time limits for making a claim can vary. In line with national trends the Trust has seen an increase in both employers' liability and clinical negligence claims over the past 12 months. All claims are subject to a scoping exercise pre-registration with the NHS Litigation Authority and a system of reflection and review to assess learning and outcomes as claims are closed.

**Care Planning Approach (CPA)**

- Factors related to care planning and being provided with a copy of the care plan continue to be an area of development identified via national service user surveys.
- Areas for development highlighted by the latest 2010/11 CPA audit include the need for continued improvement around review processes.
- Concerns related to CPA have been raised by service users and carers via dialogue groups and other forms of service user feedback.

**National Surveys**

- The Trust came in the bottom 20% of Trusts in the 2009 national staff survey for staff receiving appraisal, equality and diversity training, and suffering work related injuries. Results from the 2010 staff survey show significant improvement in numbers of staff appraised (up to 80%) but still lower than average for staff accessing diversity training.
- Although achieving section scores of 'about the same' compared to other trusts on the national service user survey our lowest section score related to crisis care. This reflects other feedback from service users and their carers that crisis care is an area where they would like to see some changes made.

## Safeguarding

The Trust ensures specialist advice and support is available. There is a safeguarding vulnerable adults lead and a named nurse and named doctor for safeguarding children.

### *Adults*

- The Trust aims to provide safeguarding adults abuse awareness training for all staff. In 2010/11 despite much targeted work we have only reached 59.9%.
- In 2010/11 there has been 1 serious case review relating to adult safeguarding. Action from this review has led to the delivery of Multi Agency Risk Assessment Conference (MARAC) briefings being delivered throughout the Trust in order to ensure staff are aware of the link between domestic abuse and safeguarding of adults.
- It is required that any allegation against staff in relation to abuse or risk of harm towards vulnerable service users be referred to the Independent Safeguarding Authority (ISA). In 2010/11 there were 6 referrals to the ISA. Unfortunately ISA do not inform organisations of the outcome of the referrals made but lessons are learned from all such incidents and action has included a review of the Trust's safeguarding adults protocol. The protocol now specifically includes new standards from the Care Quality Commission relating to the fact that care staff must not financially benefit from their contact with service users other than from their salaries.

### *Children*

- There have been 23 reported incidents in 2010/11 representing a range of occurrences where child protection and child welfare may be a feature. All incidents were managed appropriately with action taken to safeguard and protect the children in question. One amber rated incident raised issues of cross-agency communication and the responsibility of agencies to understand and participate in the CPA process. Issues raised via this incident have been discussed at the Trust's safeguarding children sub-committee. The importance of reporting safeguarding children incidents has been reinforced through a planned campaign to promote good practice and remind all staff of their individual responsibility to safeguard children.
- In 2010/11 the Trust was involved in 1 Serious Case Review involving the death of a child whose parents are known to Trust services. The overview report has now been completed and submitted for approval to the LSCB and onwards to OFSTED for scrutiny and assessment, although there will now be a delay due to legal processes. Actions identified as part of the Trust's independent management report undertaken by the Named Nurse are progressing well with the majority of outcomes already achieved.

## CQUINs

Although meeting aspects of the Regional CQUIN target related to nutrition around action planning and use of a validated tool we have not reached the specific 95% target level related to evidencing screening on admission and discharge. A significant amount of training and development has been invested to support staff to make the transition to electronic recording of the information and there has been good progress made throughout the year.

**Information Governance (IG)**

- The operating framework for 2010/11 states that trusts must reach level 2 against the Information Governance toolkit standards. Based on our provisional scoring we have identified potential non-achievement of 2 standards – those relating to the operating framework training requirements (all staff should receive basic IG training appropriate to their role through the online NHS IG Training Tool) and the clinical coding audit. Although hampered by delays in clarification of mandatory modules and availability of appropriate monitoring tools every effort has been made to facilitate staff to undertake the training and it is still hoped that we will achieve the 95% target by the extended June 2011 deadline.
- There has one serious (level 3) incident reported to the SHA and ICO in 2010/11 which has been reviewed and subsequently closed by the Information Governance Commissioner. There were a further four lower level incidents (levels 1 and 2) in 2010/11. These are not required to be reported to the Information Commissioner's Office, but have been investigated internally. It is by the understanding and diligence of our staff that we can continue to protect person identifiable information. Key messages must be effectively communicated so staff are aware of the issues and the need to report all incidents. There has been a lot of targeted staff communications related to information governance throughout the year.

**Reprovision of Services**

In 2010/11 we moved services off our main hospital site in Huddersfield into wards in North Kirklees and Calderdale. Although the project has been successfully concluded we acknowledge the anxieties of in-patient service users and their carers and some negative impacts related to the change of environment. There continues to be a workstream to identify the required bed base needs in Kirklees which will report to the Trust Board in December 2011.

**Information Sharing/Learning**

There is always a challenge in regard to how well we learn lessons from incidents and use information from audit and practice evaluation to underpin positive change. We recognise that there are areas for improvement in terms of sharing learning and positively effecting cultural change.

**Psychological Therapies Provision**

The capacity to meet the demand of referrals has meant a challenging year for Psychological Services. All three Business Development Units have undertaken targeted work in regard to data quality and improving waiting times for assessment. In March 2011, Kirklees Psychological Services undertook an intensive 5 day rapid improvement event using lean technique principles to facilitate an improved pathway for referrers and service users. Work is ongoing to implement the actions identified at this event.

**Learning from Service User Experience Feedback**

There is a need to more effectively triangulate feedback regarding the service user experience - particularly where provided by service users and carers (e.g. dialogue/focus groups, surveys, complaints) - and use this to underpin learning. Points raised via service user and carer focus groups include concerns such as carers feeling marginalised, inflexibility of clinic appointments and services not catering for individual circumstances. The Trust has clearly planned action to facilitate improvement in 2011/2012.

## 1.4.5 Regulators

Because we are a foundation trust we are accountable to local people and to an independent regulator, called Monitor. We are also regulated by the Care Quality Commission.

## 1.4.5(i) Care Quality Commission (CQC)

### Registration & Risk

- In 2010/11 we received certification from the CQC in regard to our registration without compliance conditions in respect of all activities undertaken.
- Trusts must comply with CQC Regulations in order to retain their registration. The Trust has a key performance indicator relating to any significant lapse against the CQC quality regulations – performance has been assessed as green (no lapses) throughout the year.
- The CQC now publish Quality & Risk Profiles (QRPs) on organisations. QRPs support the CQC in assessing where risks lie when monitoring compliance. The QRP combines both quantitative (numerical) and qualitative (textual) information. Where there are concerns generated by the profile CQC inspectors will need to gather further information to follow up e.g. may ask the provider to complete a Provider Compliance Assessment or where necessary may carry out a visit. The QRP scoring delineates the QRP ratings into a 4 part scale. Green and Neutral which are 'reducing risk of non-compliance' and Amber and Red which are 'increasing risk of non-compliance'. Throughout the period that the QRPs have been in operation all the trust's summary ratings have remained green or neutral.

### Mental Health Act (MHA) and Mental Capacity Act

- The 2009/10 Mental Health Act Annual Report was received in January 2011 (related to visits to the Trust made between November 2009 and October 2010). The overall report was very positive stating that: *'The overall standard of Mental Health Act administration is consistently high. Scrutiny processes are thorough and effective and Commissioners have found very few errors on admission papers or consent to treatment forms.*' The report also says that *'Commissioners have received excellent assistance from managers and staff in carrying out their work'.* The MHA Commissioner visited a total of 14 in patient clinical areas, met in private with 20 service users and reviewed a total of 29 records. Through the visits the commissioner identified a number of areas of good practice and improvements, including high quality accommodation, good interaction between staff and detained patients and good quality care planning. The commissioners have highlighted areas for further improvement such as the recording of annual physical health checks, staff awareness of MHA advocacy, recording of patients' rights and guidance on the management of seclusion. Although the Trust receives an annual report it also receives feedback following visits and has acted upon the comments of the commissioner throughout the year. Both the seclusion policy and patients' rights policy have been reviewed and updated. An audit of clinical records has been undertaken to provide a baseline to identify areas of improvement relating to the recording of information. The main priorities for Mental Health Act over the coming year will be to:
    - ensure that patients are provided with appropriate information and assistance regarding their rights under the MHA and their right to advocacy
    - implement the module for Mental Health Act on the trust's clinical information system (RiO)
    - provide support to staff through training and day to day advice regarding the use and implementation of the Mental Health Act.
- In November 2010 the Trust hosted a pilot visit on behalf of the Care Quality Commission. The visit focused on working age adult services across the Trust and involved our partner agencies, service user and carer representatives and advocacy services. The pilot visit aim was to look at the potential to undertake these visits on a bi annual basis nationally. The Trust received very positive feedback from the visit.

- Staff working within health care are also required to practice within the legal framework of the Mental Capacity Act. Training is provided to staff through a structured programme enhanced by training provided into specific service areas and also the involvement of specialist staff within 1-1 clinical sessions. The Mental Capacity Act provides a framework for people to make an advance decision regarding care and treatment should they become incapacitated in the future. The Trust has developed a template to assist service users with this. The Trust has ensured the template is legally sound and it is now available on the RIO clinical information system. Staff are actively encouraged to discuss the making of an advance decision with service users under their care.
- The legal services department has developed a robust system of engagement with Her Majesty's Coroners. In the past 12 months the Coroners for our area have come into the Trust to provide an insight into the Coroners inquest and answer questions raised by professionals. Both Coroners also attended the suicide prevention workshop hosted by the trust in November 2010 which involved the 3 Primary Care Trusts, Local Authorities and the police.

## 1.4.5(ii) Monitor

As an NHS Foundation Trust we have had to confirm our compliance with our authorisation in relation to all healthcare targets and indicators listed in Appendix B of Monitor's Compliance Framework. We have submitted green risk ratings for all four quarters of 2010/11.

# Part 2

# 2.1 Priorities for improvement

## 2.1.1 Identification of priorities

The Trust should understand and determine its quality priorities year on year.

***2010/11***
Information on our performance against 10/11 priorities is given in Part 3. A detailed review of our 2010/11 quality plan is given as table 2 (pages 33-38) which shows significant work undertaken within the organisation to support improvement against the five priority areas.

***2011/12***
Quality priorities for 2011/12 are shown as table 3 (page 38).

There have been various ways in which quality priorities for 2011/12 have been determined:

- Throughout 2010/11 there have been ongoing engagement processes providing the opportunity for stakeholders to identify key quality themes and issues that they believe should be both current and future priorities. Within this work there has been engagement via service user and carer dialogue groups, a clinician group, the Trust's members council, 3 PCT commissioners (via a Mental Health Quality Board), LINks and Overview & Scrutiny Committees.
- Compliance/quality and performance monitoring and reporting processes throughout 2010/11 have identified challenges which have shaped our understanding of priorities for quality improvement.
- Surveys, the programme of clinical audit and practice evaluation activity and complaints have been other key sources of information for identifying where quality improvements are desirable.
- Serious Untoward Incidents and the learning generated from reviews is another critical means by which required quality improvements are identified.

Contracting and CQUIN specifications are the vehicle by which we understand our commissioners' quality priorities. All agreed CQUINs are in themselves quality priorities and details are provided on pages 48-53. The list of CQUINs is not repeated within this section.

A long list of potential quality priorities drawn from analysis of the various data sources was reviewed by the Executive Management Team (EMT) on 10th February 2011. From the long list the EMT determined the priorities short list with recommended leads and actions (to be formulated into the 2011/12 quality improvement plan).

Both the long and shortlist of priorities was presented to the Trust Board on 29th March where board members approved a final quality priorities shortlist for 2011/12.

**Table 2 Quality Plan 2010/11 (Green – Fully Achieved; Amber - Partially Achieved; Red – Not Achieved)**

| Patient Experience | | | | |
|---|---|---|---|---|
| **Priority** | **Theme** | **Identified need/action** | **Outputs Achieved** | **Status** |
| All | Strategy | Develop and implement an organisational strategic framework for service user experience | Production of Customer Excellence Framework incorporated into Involving People Strategy | |
| | | | Trust's Single Equality Scheme & Service Improvement Plan refreshed 10/11 | |
| Mutual respect | Providing good information | Review and improve standards in regard to information provided to service users and carers | Review and update of web based information about the Trust and its services. BDUs reviewing all the printed service information | |
| | Attitudes and behaviours | Promote and evaluate mutual respect initiatives | Monthly feedback at extended EMT (Senior managers meeting) Quarterly compliance report feedback | |
| | | Facilitate staff to acknowledge, recognise and learn if something goes wrong | Reduction in complaints about staff attitude | |
| Personalised Care | Volunteering/ befriending service | Review and support appropriate use across the Trust | Gradual increase in the use of the befriending service over the past year. | |
| | Advanced directives | Promote better understanding/use of advanced directives and evaluate their take up/use by service users | Web based service user information to support decision making. CPA and personalised care plans support use of advanced directives | |
| | Good communication | Evaluate and improve customer care service and dialogue groups | Dialogue groups evaluated for membership, impact on service developments | |
| | | Ensure effective communication re: service change/organisational change management programme | Members' council fully informed of organisational changes. Website has details of organisational change management programme and regular updates in staff briefings and website | |
| | | Ensure feed back provided to service users and carers on how their views, input and experiences have influenced change | Feedback to dialogue groups and service specific service user groups on how their feedback has directly impacted on service change | |
| | Privacy, dignity and feeling safe | Continue to implement all required measures to eliminate mixed-sex accommodation | Quarterly Eliminating Mixed Sex Accommodation (EMSA) reviews | |
| | | Promote action to ensure service users and carers are treated with dignity and respect | Monitored | |
| | | Review, monitor and implement action to ensure service users feel safe on in-patient areas | Survey returns | |
| Improving practice/ positive outcomes | Access to local services that meet needs | Ensure range of local accessible services that meet people's needs | Move to Business Delivery Units gives locality focus to meeting needs of the local population. Closer working relationships with commissioners and with partner organisations supports local accessible services. Transforming community services agenda has enabled closer partnership working across pathways e.g. Dementia transformation in Kirklees and Calderdale. | |
| | | Continued improvements to in-patient areas including review/support re: Internet access, physical health support, exercise facilities, meaningful and structured activity provision, effective and timely discharge procedures | Move from St Luke's Hospital has improved accommodation for in patient wards. Move to Ward 19 at Priestley Unit provided purpose built accommodation. Implementation of productive mental health ward has identified actions to support releasing time to care so that more effective time can be spent in clinical care | |

| Patient Experience | | | | |
|---|---|---|---|---|
| **Priority** | **Theme** | **Identified need/action** | **Outputs Achieved** | **Status** |
| | | Implement, evaluate and report against Regional CQUIN targets:- Improving access for people experiencing acute mental health problems | Green on performance dashboard. | |
| | | Improving access for people experiencing non acute mental health problems | Green on performance dashboard. | |
| | Equal & fair access to services | Continued promotion of 24 hour crisis provision in all areas | Development of Single Point of Access commencing in Kirklees area | |
| | | Consistency of service provision re: Insight & recovery services | Review and redesign of pathway provides further opportunities to provide consistent and effective services. | |
| | | Reduce clinic cancellations | Clinic times and locations have been reviewed. | |
| | | Reduce waiting times | Commenced Lean transformation programme with psychological therapies with aim of significantly reducing waiting times | |
| | | Implement, evaluate and report against Regional CQUIN targets: Improving outcomes for BME clients | Green on performance dashboard. | |
| | | Improving standards of care and compassion – nutrition & pressure ulcers | CQUIN indicator | |
| | | Meeting the needs of people with a learning disability | Protocol agreed in regard to joint working with MH and LD services in regard to access to crisis services | |
| | Support in the community | Improve/strengthen quality of community services | Initiating productive community services so that they can review their working practices and release time to care. Large scale redesign of community mental health services has been undertaken leading to more pathway focussed service provision. Acquisition of more community services in Calderdale, Wakefield and Barnsley will continue to strengthen our community services | |
| | Evaluation | Review of service user experience and ongoing processes of gathering feedback effective in organisational learning and facilitating change | Reporting arrangements and KPIs relating to customer services reviewed to support BDUs and provide assurance to EMT and Trust Board | |
| | Integrated health and social care | Promote measures to facilitate effective integrated care arrangements; Deliver the CPA Policy; Evaluate and improve the quality of care planning; Facilitate service user and carer engagement in decision making; Promote enablement and choice | CPA policy delivered June 2010 | |
| Environment & hotel services | | Continue to closely monitor environment and food quality and implement any required improvement action | Patient Environment Action Team (PEAT) reports completed on in-patients wards. Productive MH ward Mealtimes module completed on some wards supporting changes to how mealtimes are managed. Protected time on wards during meal times. | |

| Safety | | | | |
|---|---|---|---|---|
| **Priority** | **Theme** | **Identified need/action** | **Outputs Achieved** | **Status** |
| Improving practice/ positive outcomes | Accessible and appropriate crisis services | • Continued promotion of 24 hour crisis provision in all areas<br>• Ensure a review of quality of crisis services is completed and acted on | Single point of access being developed in Kirklees to support the "Right first time" service is provided for people who require support. Further work required in 2011/12 on enabling access to people in crisis and providing adequate and appropriate support. | |
| Environment & hotel services | Environment | Continue to implement all required measures to eliminate mixed- sex accommodation. Ensure environmental risk assessments are regularly undertaken and results lead to implemented action. Maintain and take action in regard to programme of PEAT audits. Review gender mix on wards/units and report with recommendations for any appropriate action. | Quarterly EMSA reviews<br>PEAT audits undertaken to ensure accommodation and facilities are fit for purpose.<br>Regular patient experience questionnaires undertaken to understand issues related to accommodation for our service users. Tender process completed to implement service user feedback kiosks in in-patient areas<br>Review of gender specific wards - potential lead by Quality Academy during 2011/12. | |
| Suicide prevention and risk management | Safeguarding | Ensure all safeguarding procedures and training continue to meet national and locally agreed safeguarding standards (for both adults and children). Review and report against risks/support for vulnerable adults on wards | Safeguarding training mandatory for all staff members. Safeguarding leads support staff with individual advice as and when necessary.<br>SWYPFT staff attend the local safeguarding boards. Wakefield received positive Ofsted report | |
| | Individual Risk assessments | Ensure and demonstrate that risk assessments are being undertaken at the appropriate time and to the appropriate level across all teams. | Risk assessment and identification is incorporated into the CPA process. Staff are receiving training related to CPA and this training reiterates the risk assessment process | |
| | Suicide prevention | Ensure production and implementation of suicide prevention strategy. Continue to monitor/maintain appropriate 7 day discharge follow up and review quality of such follow up. | Suicide prevention conference hosted in November 2010.<br>Performance reports demonstrate continuous achievement of 7 day discharge. The Trust is investing in master class training in suicide prevention techniques that have recently been developed in the country. | |
| | SUI process | Ensure continued focus/action in regard to learning and, foe example, high risk areas such as Falls incidents in older people services and MAV incidents in adult services | Development and implementation of an Incident review committee, which reviews the investigation reports, pulls out learning, collates and disseminates lessons learnt. Learning framework currently being developed across the organisation.<br>Policies related to this area have been reviewed and refreshed this year. | |
| | Infection, prevention and control | Continue rigorous monitoring of inpatient areas and ensure continue to meet all provisions of the Hygiene Code & maintain HCAI registration | Compliance with hygiene code is monitored routinely.<br>Involvement in system wide pressure sore prevention programme. No pressure sores acquired during in patient care. | |
| | Falls reduction and prevention | Implement, evaluate and report against Local CQUIN target<br>Falls reduction and prevention | Launch of falls strategy June 2010.<br>CQUIN indicator regularly monitored and reported, providing assurance that target being met. | |

| Effectiveness | | | | |
|---|---|---|---|---|
| **Priority** | **Theme** | **Identified need/action** | **Outputs Achieved** | **Status** |
| Improving practice/positive outcomes | Strategy | Develop and implement an organisational quality framework | Quality Improvement strategy written and presented to EMT, extended EMT, Clinical Governance Committee and Board | |
| | Workforce Skills/ Knowledge | Maintain/improve/update workforce skills and knowledge base<br>Ensure supervision and appraisal is appropriately audited/reviewed and action taken to address any deficits<br>Promote library development to support organisational and practice development<br>Support, promote and develop improved professional and clinical leadership | Robust workforce development programme available supporting development of clinical and leadership skills.<br>Targets set to ensure all staff receive a meaningful appraisal every year.<br>Clinical leadership strengthened by the introduction of Heads of Service roles in each Business Delivery Unit.<br>Allied Health Professional (AHP) leadership strengthened by appointment of Clinical lead occupational therapist in each BDU and a similar clinical lead role in psychology is currently being developed. | |
| | Organisational Learning | Ensure there are clear organisational processes in regard to learning from both SIs and from things we do well – that these are reviewed/evaluated and reported on<br>Ensure that all new services are reviewed post-implementation to assess intended change/benefits are being realised | Learning framework has been developed, initially focussing on learning from SI's but this is being expanded to focus on learning from all patient experience feedback that is available e.g. complaints, incidents, patient stories, dialogue groups etc.<br>Learning from Incidents shared at extended EMT on a regular basis | |
| | Data Quality | Complete and report on organisational data quality review<br>Ensure good quality clinical recording/coding improved and maintained in line with information governance requirements | Data quality report presented at Board in December 2010. Work has been ongoing within the performance and information team over the last year to support improved data quality in terms of RiO inputting and reporting. | |
| | Clinical Information Systems | Continue to promote/facilitate RiO development and use to best effect in terms of supporting practice | Performance and information team working closely with BDU's and individual services to understand reporting requirements and ensure that RiO reports support operational decision making. | |
| | Clinical Pathways | Continue to promote/facilitate pathways and packages development<br>Specifically define/describe/evaluate pathways within agreed CQUIN targets | Clinical Decision Support Tool has been revised this year to support pathway development. This work has supported the progress of the service offer. This work will continue over the next year as BDU's develop | |
| | | Implement, evaluate and report against Local CQUIN targets<br>• Development and implementation of an integrated Dementia Pathway across mental health & learning disability, community and acute sectors<br>• Development and implementation for age appropriate environments, for children and young people; aged 16 – 18 years requiring emergency mental health assessment.<br>• Readiness to implement Care Pathways and Packages | BDU Director taking a system wide lead on the transformation of dementia services in Calderdale and Kirklees leading to changes in practice across the pathway. A pilot of in-reach services into acute hospital to support effective discharge has been extremely successful and this model is being expanded to look at in-reach into A&E and Medical assessment Unit (MAU) | |

| Effectiveness | | | | |
|---|---|---|---|---|
| **Priority** | **Theme** | **Identified need/action** | **Outputs Achieved** | **Status** |
| | Research & Development | Ensure R&D activity adequately supported and undertaken within the bounds of research governance | The SLA arrangements for research support have been reviewed and as a result SWYPFT have decided to bring research support and resources into the organisation. This will provide a strong foundation next year to support research in amore robust manner. Close links are being established with HIEC and the Quality Observatory to ensure that the Trust takes advantage of resource and expertise available. | |
| | Clinical audit & practice evaluation | Develop and implement a clinical audit and practice evaluation policy. Improve processes to ensure effectiveness in terms of identification, delivery and learning from the organisational clinical audit and practice evaluation prioritised programme. Facilitate/ promote audit and evaluation processes which support benefits realization assessments for significant trust projects. | A full clinical audit programme has been completed this year with 72 clinical audits being supported across the organisation. A process has been developed to ensure the audits within the plan fit with organisational objectives and consultation with BDU's is currently ongoing to develop the 2011/12 plan. The clinical audit and practice evaluation (CAPE) group provide expertise and governance to the clinical audit and practice evaluation work within the organisation providing clear accountability and assurance to the Board via the Clinical Governance Group. | |
| | innovation | Ensure definition and implementation of Quality Academy. Foster development/use of Quality Tools and techniques e.g. productive series | The Quality Academy has developed since October 2010. A second prospectus will be launched in June 2011. All support services have inputted into the new prospectus and have revised their "offer" to the BDUs based on four areas of practice – routine support, quality improvement, support to maintain compliance and horizon scanning. A quality improvement strategy has been developed and ratified through the Board. A Lean programme has been secured – supporting training and rapid improvement activities across the organisation | |
| | Practice development | Facilitate consistency of medical practice and prescribing across the organisation against good practice standards. Promote improvements in use of recognised psychological interventions. Ensure practice and service delivery is compliant with relevant NICE Guidance. Promote improvements in proven areas of good practice such as physical health care. Facilitate review/consideration of new/different therapeutic approaches and ensure that new practice is thoroughly evaluated for efficacy. | Effective development and implementation via Drugs & Therapeutics Trust Action Group. Development of workforce training and development strategy aligned to the skills required for the delivery of the care pathway. This includes the identification of extended roles such as the further development of non-medical prescribing. | |

| Effectiveness | | | | |
|---|---|---|---|---|
| **Priority** | **Theme** | **Identified need/action** | **Outputs Achieved** | **Status** |
| | Outcome Measures/tools development | Review/explore potential use of the outcomes star within care planning. Continue to evaluate impact/change from roll-out of recovery model across adult inpatient areas. Define and introduce appropriate patient experience measures and patient related outcome measures with increased focus on 'real time' measurement. Facilitate setting and measuring quality targets at clinical team level | Implementation of the recovery star linked to CPA and care planning as a client based outcome. Assessment tool developed to support recovery star. Discussions with Quality Observatory about supporting measures development so that reporting can occur from individual client, team and service level. | |
| | | Implement, evaluate and report against Local CQUIN target:- Develop Patient Reported Experience Measures (PREMS). Review true experience of patients throughout their healthcare cycle and evidence improvements in patient reported experience. | Reporting patient experience as required through CQUIN – all green against targets. Secured funding to implement real time patient experience kiosks across the organisation so that this information can support practice development and a better understanding of patient experience. | |
| | | Implement, evaluate and report against Local CQUIN target: Improving the physical health needs of mental health clients | Green against CQUIN target | |
| | Local Contracting Indicators/ Targets | Collect/collate/report against quality indicators via quarterly compliance/quality report and quarterly | Processes in place to report against quality indicators within the performance framework – Quality Report includes: CQC/Monitor targets, reviews, surveys; Clinical audit & practice evaluation; Infection prevention & control; Safeguarding; SUIs; Risk assessment; Safety Alerts; Complaints | |

**Table 3: Priorities for improvement (2011/12)**

| PRIORITY THEME | SPECIFIC PRIORITY | RATIONALE | QUALITY (DARZI) CATEGORY | | |
|---|---|---|---|---|---|
| | | | Eff | Safe | Exp |
| **Access** | 1. Better definition and more effective integration of the role of the crisis and acute services | • Responding to customer feedback<br>• Multi-stakeholder identification of need to assist/support the development of the acute pathway | ✓ | ✓ | ✓ |
| | 2. Developing and implementing an effective single point of access (SPA) | • Business planning to develop a district SPA for all 3 districts<br>• Supported by members' council | ✓ | | ✓ |
| **Pathways** | 3. Developing and supporting the role of the care co-ordinator | • Fundamental to delivering high quality care at the right time and right place | ✓ | ✓ | ✓ |
| | 4. Defining and measuring outcomes | • To further develop quality outcomes<br>• Transparency in outcomes | ✓ | | |
| | 5. Effective working with primary care and other providers | • Equity & Excellence/Commissioning for patients/ Development of GP consortia<br>• Further development of partnership working | ✓ | | ✓ |
| **Care and care planning** | 6. Better meeting physical health care needs | • Caring for the whole person and the alignment of physical and mental health care | ✓ | ✓ | ✓ |
| | 7. Implementation of the Recovery Star to underpin care planning | • Nationally recognised model of recovery by all sectors<br>• Self assessment of recovery by the service user | ✓ | | ✓ |
| | 8. Improved focus on person centred care/individualised budgets/personal health budgets | • Recognition of this development by Local Authorities and the development of enablement | | | ✓ |
| **Mutual respect** | 9. Measuring the service user experience and acting on it | • Real-time customer service feedback and providing real time feedback | ✓ | | ✓ |
| | 10. Increasing/improving customer care | • To further develop the quality of care delivery and the enhancement of person centred care<br>• Service User surveys/ feedback/complaints themes | | | ✓ |
| **Environment** | 11. Maintenance of a clean, safe environment | • Importance of the right environment to deliver care | ✓ | ✓ | ✓ |
| **Carers** | 12. Improving communication with carers of all ages | • Addressing the needs of carers, listening to carers and supporting them | ✓ | | ✓ |

The Trust has considered the inclusion of identified quality priorities related to services acquired post-April 2011. Quality priority themes are intentionally broad to enable additional quality priorities identified via Transforming Community Services – see part 4 – to be readily incorporated within these.

### 2.1.2 How progress against identified (11/12) priorities will be monitored and measured

- A Trust Lead will be assigned to ensure oversight and direction for each priority
- Appropriate Key Performance Indicators will be defined against each priority
- Identified indicators will be monitored and reported throughout the year
- Priorities will be reflected in the Trust audit and evaluation processes
- Priorities will be reviewed and debated within ongoing stakeholder engagement processes throughout 2011/12
- Processes will be established to ensure performance against the CQUIN (Commissioning for Quality and Innovation) targets can be monitored

### 2.1.3 How progress to achieve the priorities will be reported

- Identified indicators will be reported within Trust Board reporting schedules and processes
- The Trust's prioritised audit and evaluation programme will be monitored throughout the year which will enable issues relating to the quality priorities to be identified and reported
- Stakeholder engagement processes throughout 2010/11 will be reported to the Trust Board
- The CQUIN targets will be reported quarterly in line with contractual monitoring and quality review processes with PCT commissioners

## 2.2 Review of services

### 2.2.1 Service review

During 2010/11 South West Yorkshire Partnership NHS Foundation Trust provided and/or subcontracted 68 NHS services. The Trust has reviewed the data available to them on the quality of care in all of these services. The income generated by the NHS services reviewed in 2010/2011 represents 100% of the total income generated from the provision of NHS services run by the Trust for 2010/2011.

Throughout the year the Trust has reviewed safety, patient experience and effectiveness via the following processes:

- Trust Board, Executive Management Team and Business Delivery Unit performance monitoring, challenge and review processes – including development of improved performance dashboard
- Service accreditation processes
- Prioritised clinical audit and practice evaluation programme
- National and local survey results
- Analysis of complaints
- With PCT commissioners – monitoring and review of quarterly quality reports, contract and CQUIN monitoring processes
- As part of the development of Business Delivery Units the Trust is developing a set of leadership and management competencies to support transformational change. All heads of service, clinical leads and general managers are undertaking a tailored development programme beginning with 360° review with skilled feedback provided on the analysed results. A two day development centre informs individually tailored development programmes.
- Stakeholder engagement processes associated with the development of the Quality Account
- Development of the customer care strategy based on feedback/engagement with stakeholders regarding service quality including moving forward on real-time feedback
- An incident review sub-committee (of the clinical governance and clinical safety committee) established to review all Serious Incidents reports, recommendations and learning.
- Quarterly NICE compliance reporting
- Twice yearly self-assessment against the Care Quality Commission quality regulations
- Review processes associated with the development of a new quality improvement strategy
- Suicide prevention workshop supporting the development of the suicide prevention strategy
- Environmental reviews have underpinned improved processes such as in one new centre each service user being met in the waiting lounge by the clinician who is going to see them.
- Listening to our service users there has been planning for a single point of access (a single number to call) which goes live in Kirklees in June 2011. Wakefield and Calderdale to follow on later in the year.

### 2.2.2 Participation in clinical audit

Clinical audit and evaluation involves reviewing the delivery of healthcare to ensure that best practice is being carried out. Effective clinical audit and practice evaluation is critical to the development and maintenance of high quality person-centred services.

During 2010/2011 twelve national clinical audits and one national confidential enquiry covered NHS services that South West Yorkshire Partnership NHS Foundation Trust provides. During that period South West Yorkshire Partnership NHS Foundation Trust participated in eleven (92%) national clinical audits and one (100%) national confidential enquiry of the national audits and national confidential enquiries, which it was eligible to participate in. The national clinical audits and national confidential enquiries that South West Yorkshire Partnership NHS Foundation Trust was eligible to participate in during 2010/2011 are as follows: (see table 4 below).

**Table 4: National clinical audits**

| The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2010/2011 are as follows: | | | Trust participation 2010/2011 |
|---|---|---|---|
| National Audit of Psychological Therapies for Anxiety and Depression (NAPT) | | | ✓ |
| National Audit of Falls and Bone Health | | | ✓ |
| National Organisational Audit of the Implementation of NICE Public Health Guidance for the Workplace by NHS Trusts | | | ✓ |
| National Audit of Depression and Management of staff on long term sickness absence by Occupational Health Services in the NHS: Round 2 | | | ✓ |
| National Audit of Schizophrenia | | | ✓ |
| Prescribing Observatory for Mental Health (POMH) prescribing topics in mental health services | Topic 1e | Prescribing high dose and combined antipsychotics on adult acute and psychiatric intensive care wards | ✓ |
| | Topic 2e | Screening for metabolic side effects of antipsychotic drugs | ✓ |
| | Topic 7b | Monitoring of patients prescribed lithium | ✓ |
| | Topic 8b | Medicines reconciliation | ✓ |
| | Topic 9b | Use of antipsychotic medicine in people with learning disabilities | ✓ |
| | Topic 11a | Prescribing for antipsychotics for people with dementia | ✓ |
| National confidential inquiry into suicide and homicide by people with mental illness | | | ✓ |
| National health promotion in hospitals audit | | | |

The national clinical audits and national confidential enquiries that South West Yorkshire Partnership Foundation Trust participated in during 2010/2011 and for which data collection was completed during 20010/11 are listed below (as Table 5) alongside the number of cases submitted to each audit or enquiry. The percentage of the number of registered cases required by the terms of that audit or that enquiry is not specified. The Prescribing Observatory for Mental Health (POMH) audits do not specify a minimum number in their sampling framework criteria.

**Table 5: National clinical audits data collection 2010/2011**

| Audit | Data collection period | Number of cases submitted |
|---|---|---|
| National audit of schizophrenia | August 2010 | Consultation questionnaire completed on draft standards and outcome |
| National audit of falls and bone health in older people | September 2010 | N=1 organisational questionnaire |
| National organisational audit of the implementation of NICE public health guidance for the workplace by NHS Trusts | September 2010 | N=1 organisational questionnaire |
| National audit of psychological therapies for anxiety and depression | May 2010-February 2011 | N=1 service questionnaire; N=800 service user questionnaires distributed; N=16 therapists requested; N=745 data extract (Responses sent direct to NAPT) |
| POMH Topic 9b: Use of antipsychotic medicine in people with learning disabilities | January 2011 | N=168 (no minimum sample identified: Four teams collected data from outpatient clinics) |
| POMH Topic 11a: prescribing of antipsychotics for people with dementia | March 2011 | Data collection in progress. (minimum sample of 10 cases per consultant psychiatrist team N=130) |
| National confidential inquiry into suicide and homicide by people with mental illness | April 2010-March 2011 | 19 questionnaires received from the NCI in year. 21 returns made in year. 2 outstanding. |

**National clinical audit – action**

The reports of five national clinical audits were reviewed by South West Yorkshire Partnership Foundation Trust in 2010/2011 and South West Yorkshire Partnership Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see table 6 overleaf)

**Table 6: National clinical audit – action**

| Audit and data collection period (number submitted) | Summary results | Actions |
|---|---|---|
| POMH Topic 1e: Prescribing high dose and combined antipsychotics on adult acute and psychiatric intensive care wards<br>Jan 2010<br>N=69 | 65% prescribed within BNF limits<br>58% individuals receive one antipsychotic at a time<br>71% first (typical) and second generation (atypical) are not prescribed concurrently | A new prescription and administration chart is being introduced, which will include a rapid tranquilisation specific section.<br><br>This should reduce the number of individuals prescribed more than one antipsychotic at a time. |
| POMH Topic 2e: Screening for metabolic side effects of antipsychotic drugs<br>Feb 2010<br>N=170 | Annual screening achieved:<br>46% blood pressure recorded<br>72% blood glucose levels<br>61% blood lipids<br>44% BMI or other measure<br>Smoking target:<br>22% did not smoke<br>22% offered help with smoking cessation<br>56% not offered help<br>96% prescribing within BNF limits | A working party has been set up as part of the drug and therapeutics committee to investigate the way forward.<br><br>The Trust is setting up outpatient clinics for smoking cessation. |
| POMH Topic 7c: Monitoring of patients prescribed lithium<br>April 2010<br>N=59 | Before initiating lithium treatment:<br>75% renal function tests recorded<br>100% thyroid function tests<br>75% weight or BMI or waist circumference<br>Maintenance therapy:<br>56% serum lithium levels 3 monthly<br>58% renal function tests 6 monthly<br>51% thyroid function tests 6 months<br>65% weight or BMI or waist circumference | The Trust's Lithium safety group has:<br>o Adopted the use of the NPSA patient information leaflets, lithium alert cards and record books for tracking blood tests.<br>o Minor capital bid submitted for the DAWN system (lithium register)<br>o Training pack developed for use on lithium<br>o Shared care guidelines revised<br>o Re-audit Sept 2011 |
| POMH Topic 8b: Medicines reconciliation<br>Sept 2010<br>N=49 | 25% discrepancy identified with the medication regimen<br>35% approximately fewer than 2 sources checked | Report reviewed. For presentation at May 2011 drug &therapeutic committee with a view to amending the policy, defining responsibilities, including the medication history form on Rio and proposing extending the role of pharmacy technicians in the medicines reconciliation process. |
| National Audit of Depression and Management of staff on long term sickness absence by Occupational Health Services in the NHS: Round 2<br>May-Aug 2010<br>N=39 | Results for the Trust were higher than the national averages, showing that the Trust has robust assessment processes in place. There are cases where at the point of referral employees are being assessed to return to work and an assessment of depression is not relevant at that stage. The extended week's absence at referral for the Trust is 1 or 2 cases and it was appropriate in each case that they were referred at a point of contemplating a phased return (i.e. an oncology diagnosis) | *To be specified* |

## Local audits

The Trust undertakes a significant programme of clinical audit. Clinical audit and evaluation involves reviewing the delivery of healthcare to ensure that best practice is being carried out. Effective clinical audit and practice evaluation is critical to the development and maintenance of high quality person-centred services. A total of 78 clinical audits and practice evaluation projects were prioritised in the 2010/11 trust programme some of which are included in this section of the quality account. Key audits have an organisational level review. In addition a number of projects have also been completed by individual teams, localities and care groups which include documentation and local drug audits (n=33). All completed audits are reviewed locally by the project leads and teams involved.

As part of the prioritised audit programme in 2010/11 the Trust included audits to support the regional and local CQUIN (Commissioning for Quality and Innovation) reporting requirements.

The reports of eight local (Trust-wide) clinical audits were reviewed by South West Yorkshire Partnership Foundation Trust in 2009/2010 and South West Yorkshire Partnership Foundation Trust intends to take the following actions to improve the quality of healthcare provided (table 7).

**Table 7 Local clinical audit action**

| Audit and data collection period | Summary results | Actions |
|---|---|---|
| Annual ECT audit (NICE) 2010-2011 | Annual audit demonstrates compliance with the NICE guidance | No specific action identified as fully compliant with all NICE requirements. ECT awarded ECTAS accreditation with excellence for the 2nd time in October |
| Annual prescription chart audit<br>April 2010 | Annual audit to assess compliance with the Medicines Code | Overall compliance improved or remained the same. Presented to local medical audit groups and action plan implemented. New prescription charts will be piloted Spring 2011. |
| Annual missed dose audit<br>Feb 2010 | Annual audit priority to assess compliance with Medicines Code | Completed July 2010; Missed dose audit tool requires update to include self medication; Training required particularly in forensic. |
| Annual antibiotic audit<br>Feb 2010 | Annual audit to assess compliance with the Trust Prescribing Antibiotics Policy | 87% of antibiotic prescriptions were within the Trust policy; 17% of antibiotic prescriptions had a culture and sensitivity report available; Pharmacy staff implementing action plan to work with the nursing and medical staff to improve the audit standards. |
| Audit of information sharing across professional organisations | CQUIN local indicator 2: Supporting appropriate , safe information sharing across professional organisations | The audit demonstrated that the Trust is highly compliant with information sharing, however the Information Governance Trust Action Group needs to ensure awareness training/encourage adherence to policy for use of unencrypted emails and understanding of consent requirements |

| | | |
|---|---|---|
| Annual pressure sores audit<br><br>Data period 01/11/09 - 31/10/10<br><br>Collected January 2011<br><br>(30 wards) | There were a total of 9 service users who were admitted with or developed a pressure ulcer after admission. | The following actions were implemented after the previous report: *Modern Matrons to discuss results with relevant ward/unit managers and ensure that all clinical staff working in in-patient areas understand the importance of informing service users and carers about the care and treatment of their pressure ulcers. The need to report pressure ulcers graded 2 and above via the Trusts risk reporting procedure also needs to be emphasised.*<br>The results from the current audit indicate an improvement in the above areas. The current report is in draft format and the results are to be reviewed and actions determined.<br>The audit process and findings support locally identified CQUIN priorities. |
| Annual undetermined deaths audit<br><br>22 deaths reported to the SHA in 2009/10 (reduction from 35 reported deaths in 08/09)<br><br>Report produced August 2010 | Increased % in 45-64 group. No deaths occurred in the over 65 age group.<br>55% related to people unemployed and 9% to people with long term sickness<br>Most common methods of suicide were hanging and poisoning<br>41% of cases had a physical illness.<br>47% had history of alcohol and/or drug abuse<br>No service user died on an inpatient unit but 1 person died in A&E following transfer from a ward. | Reviewed with partner agencies. Identification of continuing good practice against suicide prevention toolkit standards. Key findings used to support practice review within Business Delivery Units and services. Findings linked to SI reviews and lessons learned processes. |
| Annual CPA audit<br><br>3 part audit – random sampling<br><br>Level 1, electronic records n = 841<br><br>Level 2, teams, random sample of case records n = 180<br><br>Level 3, service user and carer survey n = 106 | Good standards around progress note recording. Positive areas included: Care coordinator recorded 100%. 90% had a care plan recorded on RiO. 94% had Level 1 risk assessment recorded.<br><br>63% had record of CPA review in last 12 months Carer only recorded on 13% electronic records.<br><br>96% of care coordinators receiving regular supervision<br><br>71% of service users reported their care had been reviewed & 65% had had a review in the last 12 months. 56% said they had been offered copy of a care plan. 69% had an agreed care plan. 69% felt fully involved in their care planning.79% of service users knew how to contact care co-ordinator. | Audit results reviewed and used to underpin learning and promote practice development. Such as: CPA policy development, CPA training, development of improved health & social care assessment. |

The following were new local audits in 2010/11 – not fully completed at time of reporting.

**Table 8 Local clinical audit – reports not yet completed**

| Audit and data collection period | Status | Actions |
|---|---|---|
| Health and Safety annual audit<br>Nov 2010-Jan 2011 | Analysis and report in progress | The H&S Trust Action group will determine further action following review of the current audit report. |
| Annual antibiotic audit<br>Feb 2011 | Annual audit to assess compliance with Trust prescribing antibiotics policy | Summary report to be completed by May 2011 |
| Audit of Risperdal Consta prescribing<br>Aug-Dec 2010 | To assess compliance with the Trust policy | Data analysis in progress;<br>Summary report to be completed by May 2011 |
| Prescribing anti dementia drugs audit<br>Aug-Dec 2010 | To assess compliance with the NICE guidance and local policy | Data analysis in progress;<br>Summary report to be completed by May 2011 |
| CPA audit<br>December 10 to March 2011<br>Level 1 (electronic records) 914 CPA, 800 standard care<br><br>Level 2 (qualitative review from staff) 106<br><br>Level 3 (service user and carer survey) 600<br><br>Audit is for CPA and standard care | Level 1 completed<br>Level 2 completed<br>Level 3 closing date 25th March | Data analysis and report to be completed by the end of March 2011. |
| Eliminating Mixed Sex Accommodation<br><br>November 2010<br><br>27/30 wards – 3 not included due to ward moves | Audit completed and draft report completed and presented to the EMSA group – recommendations pending following presentation to Business Delivery Units | The following recommendations have been identified so far;<br>Improvement in adherence to the national standards aiming at 100% compliance.<br>Review the audit tool prior to re-audit. |
| Essence of care – Respect, privacy and dignity<br><br>February 2011<br><br>7 wards | Report completed in draft format to be presented at essence of care trust group and Business Delivery Unit | The following have been identified as areas for action: Order confidentiality leaflets for ward areas.<br>Promote valuing diversity training for staff and dignity champions. |

An Internal Audit report in 2010/11 gave an audit opinion of 'limited assurance' in terms of the Trust having in place an effective system for delivering its clinical audit strategy. As a result the trust developed a clinical audit and practice evaluation strategy, underpinned by a policy and implementation plan. The Trust has a robust prioritisation programme focused towards supporting key strategic and operational risks. All internal audit recommendations have been successfully implemented and monitored by the Clinical Governance and Clinical Safety Committee.

### 2.2.3 Participation in research

The number of patients receiving NHS services provided or sub-contracted by South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) from 1 April 2010 to 31 March 2011 that were recruited during that period to participate in research approved by a research ethics committee was 164, compared to 72 in 2009/10.

Participation in clinical research demonstrates SWYPFT's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

There were 48 clinical staff participating in research approved by a research ethics committee at SWYPFT during 2010/11. These staff participated in mental health, learning disabilities and dementia research.

SWYPFT was involved in conducting 32 clinical research studies in mental health, learning disabilities and dementia during 2010/11. Of these, 18 were National Institute for Health Research (NIHR) adopted studies. This compares favourably with the 19 clinical studies, of which six were NIHR studies conducted during 2009/10, representing an increase in NIHR study activity of 200% from last year.

Leading to Quality is a research project funded by Yorkshire and Humber Strategic Health Authority which SWYPFT is leading. It is examining the impact of leadership and culture on the effectiveness of teams and the quality of care received by adults who receive mental health services in the community and demonstrates SWYPFT's commitment to clinical research that improves patients' health and lives.

SWYPFT continued to engage service users in research design, identifying research priorities, interview panels for research staff, participating in research projects and research governance during 2010/11.

In the last three years, 3 publications have resulted from our involvement in NIHR research, which shows our commitment to transparency and desire to improve patient outcomes and experiences across the NHS.

### 2.2.4 Goals agreed with commissioners

A proportion of South West Yorkshire Partnership Foundation Trust's income in 2010/2011 was conditional on achieving quality improvement and innovation goals agreed between South West Yorkshire Partnership Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. The Trust had agreed CQUIN goals with the following Primary Care Trusts (PCTs) and local authorities: NHS Kirklees; NHS Calderdale; NHS Wakefield District; NHS Barnsley (for the medium secure forensic multi-commissioning group); Wakefield Metropolitan District Council.

Further details of the agreed goals for 2010/11 and for the following 12 month period will be available electronically at http://www.institute.nhs.uk/world_classcommissioning/pct_portal/cquin.html

### 2.2.4(i) Commissioning for Quality and Innovation (CQUIN) 2010/2011

The CQUIN payment framework makes a proportion of providers' income conditional on quality and innovation. In 2010/11 the trust has been required to deliver a regional (SHA) and a local set of quality indicators. Delivery of all the data associated with each relevant set of indicators gave trusts a payment of 0.5% of their total contract value for the regional scheme and 1.0% for the local (PCT led) indicator set. Data for each relevant indicator was submitted at the end of each quarter to the SHA and commissioning PCTs.

- The total regional CQUIN contract monetary value for the Trust in 2010/11 was £454,000. The regional CQUIN indicator list and Trust performance is shown as table 9
- The total local (PCT led) CQUIN contract monetary value for the Trust in 2010/11 was £904,000. The list of local CQUIN indicators and Trust performance against these is shown as table 10
- The Trust also agreed delivery against the regional CQUINs within its agreement with Wakefield Metropolitan District Council. The contract monetary value for the Trust in 2010/11 being £54,000.
- Forensic services have also been assessed against a number of CQUIN indicators. In 2010/2012 the total CQUIN contract monetary value for the Trust's forensic services was £356,000. The list of forensic CQUIN indicators and Trust performance against these is also shown in table 10.

The actual overall monetary CQUIN value achieved by SWYPFT in 2010/11 was £1,723,000. The £45,000 short fall resulting from only partial achievement against the regional nutrition (£32,000) and forensic service user experience (£13,000) indicators. (See tables 9 and 10).

In 2011/12 the total monetary value of 1.5% will apply to locally defined CQUINs (there is no SHA scheme). Table 11 provides detail of the proposed local CQUINs identified by the PCTs. Table 12 gives the detail of the proposed forensic CQUIN Scheme. *Note: contract negotiations ongoing with Calderdale & Kirklees PCTs at time of writing this report.* The total contract monetary value related to these 2011/12 CQUIN schemes is £1,873,000 (estimated at time of report production prior to all contracts being finalised) broken down as follows: Wakefield: £585,000 (inclusive of services acquired under transforming community services); Calderdale: £295,000 (inclusive of services acquired under transforming community services); Kirklees: £588,000; Specialist Commissioning Services (forensic): £353,000; Wakefield MDC: £52,000.

The Trust will also have a set of CQUINs in 2011/12 identified by NHS Barnsley PCT in respect of services acquired under transforming community services. Barnsley Care Services Direct performance against their 2009/10 CQUIN requirements is reported in Part 4 of this account.

**Table 9 Regional CQUIN 2010/2011**

| SHA (REGIONAL) INDICATORS | | | | Achieved | | | |
|---|---|---|---|---|---|---|---|
| **Indicator** | **Baseline** | **Trajectory** | **Products required + Timescales** | **Q1** | **Q2** | **Q3** | **Q4** |
| Improving access for people experiencing acute mental health problems | 50% | 3 year trajectory: from 50% to 80% at 10% improvement each year. 10/11 = 60%.<br>100% payment if achieved by Q3.<br>75% if achieved by Q4 | Quarterly Reports | ✓<br>74% | ✓<br>75.3% | ✓<br>79.4% | ✓<br>*73.5%* |
| Improving access for people experiencing non acute mental health problems | Pt 1 – 55%<br>Pt 2 – 90% | Pt 1 60% - must include improvement against 2 of the 3 specialities (adult/OPS/LD) and maintenance of the current level against 1<br>Pt 2 91% - must include improvement against 1 of the 3 specialities (adult/OPS/LD) and maintenance of the current level against 2 | Quarterly Reports | ✓<br>40%<br>72% | ✓<br>56% 90% | ✓<br>58%<br>92%) | ✓<br>*68%*<br>*92%* |
| Improving outcomes for BME clients | Pt 1<br>(ALOS) - White British 34 BME 42<br>Pt 2<br>(detained) - WB 119 BME 30 ( 80:20)<br>Pt 3<br>(seclusion) - WB 16 BME 11 (60:40) | 50% CQUIN value for work completed.<br>75% of CQUIN value where no deterioration/decline against Q1 baseline.<br>90% of CQUIN value achieved by improvements against parts 1 and 2.<br>100% of CQUIN value achieved by improvements against parts 1, 2 and 3 | Quarterly Reports | ✓ | ✓ | ✓ | ✓ |
| Improving standards of care and compassion – Nutrition | N/A | Screened admission – 95%<br>Screened Discharge – 95%<br>Discharged with appropriate care plans – 100%. | Screened admission. Screened Discharge. Discharged with appropriate care plans.<br>Action Plan + quarterly progress reports. | ✓<br>50%<br>55%<br>100% | ✓<br>65%<br>63%<br>100% | ✓<br>73%<br>79%<br>100% | **X**<br>78%<br>75%<br>100% |
| Improving standards of care and compassion Pressure Ulcers | Nil return all elements | 4 or less pressure ulcers of any grade (developed whilst in SWYPFT care) deemed to be avoidable over the full year (on a general basis of 1 per quarter). Therefore 3 or less for the remaining 3 quarters of the year | Action Plan + quarterly progress reports. | ✓<br>1 | ✓<br>0 | ✓<br>0 | ✓<br>0 |
| Meeting the needs of people with a learning disability | N/A | No trajectory for 10/11. | JUNE: Minutes of meetings Steering group report.<br>MARCH 18th 2011: Pilot report. Staff training report. | ✓ | - | - | ✓ |
| Dementia | N/A | No trajectory for 10/11. | SEPT: Minutes of meetings Steering group report.<br>10 DAYS POST DEC: Pilot Report.<br>MARCH 18th 2011: Pilot report. Staff training report. | ✓ | - | ✓ | ✓ |

**Table 10 Local (PCT), Local Authority and Forensic CQUIN 2010/2011**

| LOCAL INDICATORS | | | | Achieved | | | |
|---|---|---|---|---|---|---|---|
| **Indicator** | **Baseline** | **Trajectory** | **Products required + Timescales** | **Q1** | **Q2** | **Q3** | **Q4** |
| Meeting the mental health needs of children and young people (aged 16-18 yrs) within age appropriate environments | N/A | No trajectory for 10/11. | SEPT: Minutes. Steering group report. 10 DAYS POST DEC: Pilot Report. MARCH 18th 2011: Pilot report. Staff training report. | ✓ | - | ✓ | ✓ |
| Supporting appropriate, safe information sharing across professional organisations | N/A | No trajectory for 10/11. | SEPT: Minutes. Steering group report + Protocol. 10 DAYS POST DEC: 3 month review report. MARCH 18th 2011: Audit report. Staff training report. | ✓ | - | ✓ | ✓ |
| Improving patient experience | Q 18: Yes always – 69%<br>Q 22: Yes always – 56%<br>Q 26: Yes always – 58%<br>Q 27: Yes definitely – 34%<br>Q 47: Excellent – 21% | Q18: 71% Q22: 65% Q26: 71% Q27: 42% Q47:30%<br>3/5 achieved = 75% of payment<br>4/5 achieved = 90% of payment<br>5/5 achieved = 100% of payment | Survey Results<br>Survey period July-December 2010 – Discharged adult & older. | ✓ | - | ✓<br>85%<br>86%<br>89%<br>72%<br>57% | ✓ |
| Improving the physical health needs of mental health clients | N/A | 50% of staff trained.<br>Referrals (or offer) smoking cessation : at least 7% but less than 9% = 50% payment<br>At least 9% but less than 15% = 90% payment<br>Over 15% = 100% payment | Quarterly progress reporting.<br>Final report against trajectories | ✓ | ✓ | ✓ | ✓ |
| Care packages and pathways | N/A | No trajectory for 10/11. | SEPT: Minutes. Steering group report. MARCH 18th 2011: 3 month currency/costing pilots plus implementation plan | ✓ | - | ✓ | ✓ |
| Falls reduction and prevention | Pt 1 – assess 55%<br>Pt 2 – number 47 | Pt 1 - 65%<br>Pt 2 – 230 total falls in 10/11 | Baseline report Q1<br>Quarterly Reports | ✓<br>55%<br>47 | ✓<br>70%<br>46 | ✓<br>72%<br>38 | ✓ |

| LOCAL AUTHORITY INDICATORS | | | | |
|---|---|---|---|---|
| **Indicator** | **Q1** | **Q2** | **Q3** | **Q4** |
| Meeting the needs of people with a learning disability | ✓ | ✓ | ✓ | ✓ |
| Care packages and pathways | ✓ | ✓ | ✓ | ✓ |

| FORENSIC INDICATORS | | | | |
|---|---|---|---|---|
| **Indicator** | **Q1** | **Q2** | **Q3** | **Q4** |
| Safety - HoNOS | ✓ | ✓ | ✓ | ✓ |
| Innovation – EssenCES Climate Evaluation Scheme | ✓ | ✓ | ✓ | ✓ |
| Service User Experience – empowerment & involvement | ✓ | X | ✓ | ✓ |
| Service User Experience – CPA & Whole Dining Experience | ✓ | ✓ | ✓ | ✓ |
| Service User Experience – 25 hour structured activity | ✓ | ✓ | ✓ | ✓ |
| Effectiveness – recovery planning tool | ✓ | ✓ | ✓ | ✓ |

### 2.2.4(ii) Commissioning for Quality and Innovation (CQUIN) 2011/2012

**Table 11: Local (PCT Identified) CQUINs 2011/12**

| Local CQUIN description | Numerator | Final Indicator Value |
|---|---|---|
| Improving access to assessment for adult of working age and older people experiencing acute mental health problems | Number of urgent referrals (need assessment within 4 hours) (Learning Disability/Adult/Older People) receiving a face to face assessment by a qualified practitioner within four hours | 85% |
| Improving access to assessment and treatment for people experiencing non-acute mental health problems (all care groups) | Number of non-urgent referrals who are assessed within 14 days (Learning Disability/Adult/Older People)<br>Number of above commencing treatment within 6 weeks of assessment (Learning Disability/Adult/Older People) | 65%<br>95% |
| Improving access to assessment and treatment for people requiring secondary care psychological therapies | Number of new referrals to secondary care psychology assessed within 14 days (from and including 25 March 2011)<br>Number of above commencing treatment within 16 weeks following assessment<br>Develop an action plan to address backlog of referrals (all referrals up to 24 March 2011), ensuring all referrals have commenced regular treatment by 31 March 2012. | 90%<br>90%<br>Not applicable |
| Prevent and reduce the number and severity of falls sustained by inpatients (all care groups) | Number of service users having undergone a level 2 falls assessment using a validated tool within 24 hours of admission (Learning Disability/Adult/Older People)<br>Number of above assessed as 'at risk' where recommendations to reduce risk of falls is clearly documented in their care plan | 75%<br>100% |
| Prevent and reduce the number and severity of falls sustained by inpatients | a. Number of falls per month reported by severity of harm<br>b. Number of a. where the service user has had a falls reassessment following the fall<br>c. Number of falls per month reported by severity of harm (severe or death) subject to a full Root Cause Analysis investigation<br>d. Number of service users falling more than once during their stay<br>(older people reporting from Q1, adult/LD data reporting from Q2 – final indicator values based on Q2 return) | a. To be based on first quarter baselines<br>b.100%<br>c.100%<br>d. To be based on first quarter baselines |
| Improve pressure ulcer prevention and management | a. Number of service users who have one or more existing pressure ulcers on admission (Grade 2 and above)<br>b. Number of service users admitted for more than 48 hours acquiring a pressure ulcer within 10 days of admission (Grade 2 and above)<br>c. Number of incident forms completed for Grade 2 pressure ulcers and above<br>d. Number of root cause analysis investigation undertaken for patients with Grade 3 pressure ulcers and above<br>(older people reporting from Q1, adult/LD data reporting from Q2) | a. Not applicable<br>b.≤1 per quarter<br>c.100%<br>d. 100% |
| Nutritional screening | Number of service users admitted for more than 48 hours who underwent nutritional screening (using a validated tool) on admission (Adult/Older People/Learning Disability)<br>Number of above assessed as 'high' nutritional risk with appropriate referrals / continuing care plans in place<br>Number of above with appropriate care plan and onward referral at discharge<br>(older people reporting from Q1, adult/LD data reporting from Q2) | 95%<br>100%<br>100% |

| Table 11 Continued: Local CQUIN description | Numerator | Final Indicator Value |
|---|---|---|
| a. To reduce the average length of stay for inpatients with Dementia dignosis to national best practice of below 50 days<br>b. To reduce excess bed days for inpatients with a diagnosis of Dementia, defined as people staying 50 days or longer | a. Number of mental health admissions for people with a diagnosis of dementia stays of up to 50 days (ICD10 F00, F01, F02, F03)<br>b. Number of mental health admissions for people with a diagnosis of dementia stays of over 50 days ( ICD10 F00, F01, F02, F03)<br>c. 100% of exception reports for individual stays over 50 days<br>d. Agreed % reduction of excess bed days | a and b. Agreed SWYPFT average<br>c. 100%<br>d. to be agreed<br>d. To be agreed |
| To identify all service users who access community or inpatient services who confirm that they smoke on initial assessment. To provide very brief anti-smoking intervention (ask,advice,act). To facilitate access to local NHS smoking cessation programmes for those identified (all care groups). | Number of service users identified on initial assessment confirming they smoke (Adult/Older People/Learning Disability)<br>Number of above referred to NHS smoking cessation programmes | Not applicable<br>30%. |
| To record at initial assessment the level of physical activity of all service users who access community or inpatient services . To deliver brief, effective exercise advice intervention (ask,advice,act). To facilitate access to local physical activity programmes for those identified as taking less than 1 hour per week (all care groups). | Number of service users where levels of physical activity are recorded on initial assessment (Adult/Older People/Learning Disability)<br>Number of above taking less than recommended weekly physical activity with appropriate care plans or onward referral<br>(reporting from Q2) | Q2 10%<br>Q3 30%<br>Q4 ≥60% |
| To identify all service users admitted to inpatient services who on initial assessment have a recorded weight & BMI of 27 or greater. To provide brief weight management intervention (ask,advice,act) to those with recorded BMI up to 30. To facilitate access to local NHS weight management programmes for those with identified, recorded BMI greater than 30 (all care groups). | Number of service users identified on initial assessment with a recorded weight & BMI greater than 27 (Adult/Older People/Learning Disability)<br>Number of service users identified on initial assessment with a recorded weight & BMI greater than 30 (Learning Disability)<br>Number of above referred to local NHS weight management programmes | Q2 40%<br>Q3 60%<br>Q4 100% |
| For agreed, recognised outcome measures (to agree either HONOS or outcome star) appropriate to service user groups, to be used at 6 monthly CPA reviews. This will enable SWYPFT to submit data in a manner and format that will enhance both provider and commissioner understanding of groups of service users through their care pathways. The data submitted will support the ongoing development of MH PBR/personalisation (all care groups). | The percentage of service users (Adult/Older People/Learning Disability) on CPA at any point in the period who<br>• Show an improvement in outcome score<br>• Maintain same outcome score<br>• Show a worsening outcome score | 100% |
| To improve service users experience across inpatient and community services | Quarterly score of 15 questions with evidence that the service users surveyed are representative of all services provided by SWYPFT. | to be agreed |

## Table 12: Medium and Low Secure Services Commissioning for Quality and Innovation (CQUIN) 2011/2012

| Goal number & Quality domain (weighting) | Description of Goal | Description of Indicator number/name | Description of Information Requirement | Payment Period |
|---|---|---|---|---|
| 1. Essen Scale (10%) | The ESSEN Scale is a tool designed to assess the therapeutic climate within a care setting. It is explores the degree to which service users feel safe and supported by both their peers and care staff. Evidence suggests that service users respond better and engage more in treatment, and thus reduced length of stay, where they feel safe and comfortable. Service developments informed by feedback from this tool will enhance the therapeutic climate of care settings. | Providers are required to develop, where appropriate, on their work of 2010/2011 in regard to the implementation of the ESSEN Scale. It is expected that the ESSEN Scale, or similar, will continue to be implemented during 2011/2012. This CQUIN is designed to encourage the development of service developments/improvements informed by the output from previous use of the ESSEN Scale. Service developments should aim to improve the service user experience and clinical outcomes. | Q1. By the end of quarter 1 provider will have identified a service development/improvement informed by the output from 2010/2011 ESSEN surveys, or a similar survey tool. Provider will provide an implementation plan that delivers the service development/improvement by quarter 4.<br>Q2/3. Provider to submit written update on progress against implementation plan including any slippage against plan.<br>Q2/3. Provider to submit written update on progress against implementation plan including any slippage against plan.<br>Q4. Provider to demonstrate implementation of agreed service development/improvement, articulating the intended improved outcomes in service user experience and clinical outcomes. | Quarterly |
| 2. HONOS (10%) | HONOS is a recognised clinical outcome measure. Data collected will demonstrate a service user's journey through their care pathway. Aggregate data will assist the future development of tariff for secure mental health services | For the provider to continue to use the HONOS outcome measure appropriate to their service user group. The provider will be required to submit data in a manner and format that will enhance both provider and commissioner understanding of groups of service users through their care pathways. The data submitted through this CQUIN will inform the future process of agreeing an appropriate tariff for secure mental health services. | Q1. By the end of quarter 1 the provider will have developed a recording/reporting system that identifies the percentage of service users per unit who,<br>□ Show an improvement in score<br>□ Maintain same score<br>□ Show a worsening score<br>Reporting should be via six month CPA reviews.<br>Q2/3. Provider to submit scores to commissioners by percentage of service users in the above three categories.<br>Q2/3. Provider to submit scores to commissioners by percentage of service users in the above three categories.<br>Q4 Provider to submit report giving overall percentage of service users within the three categories. Report should demonstrate analysis of data in order to describe the characteristics of the service users within the three categories. Characteristics may include for example those service users recently admitted or those identified as being long term or treatment resistive. | Quarterly |

| Table 12 Continued | | | | |
|---|---|---|---|---|
| **Goal number & Quality domain (weighting)** | **Description of Goal** | **Description of Indicator number/name** | **Description of Information Requirement** | **Payment Period** |
| 3. Length of Stay (20%) | This CQUIN will assist in the delivery of the Specialised Commissioning Team's QIPP. | A fundamental element of both the national and regional QIPP schemes for secure services relates to reducing the current length of stay within secure hospitals. This CQUIN is intended to incentivise providers to better understand their current lengths of stay and develop strategies to reduce them. | Q1. Provider to develop systems for recording and reporting length of stay of all service users within the hospital. Length of stay is to be recorded from admission to, where an episode of care is completed, discharge from the hospital to a different level of security. Providers will be required to report source of admission and destination on discharge. Length of stay of all incomplete episodes of care should also be included.<br>Q2. Provider to submit length of stay data as above to commissioner for all service users for whom the commissioner has commissioning responsibility within the hospital.<br>Q3. By Q3 the output from the Pbr development work for secure services should have identified a number of specific clusters. Providers are required to develop systems that will capture length of stay for service users in each cluster.<br>Q4. Provider to submit a report demonstrating how they will positively impact on current length of stay of service users within their hospital.<br>To submit a report that describes the length of stay by cluster. | Quarterly |
| 4. 25 hours meaningful activity (10%) | Evidence suggests that boredom and reduced motivation results in poorer clinical outcomes for service users within secure care. This CQUIN promotes a balanced and structured day involving meaningful activity linked to service users agreed care plans that promote recovery. Implementation of the CQUIN will enhance the experience of care and enhance clinical outcomes. | Providers will continue to embed the development of service user defined activity plans within services ensuring that these link to the shared pathway work stream, in relation to recovery and service user outcomes. | Q1. Using the agreed national definition of 'Meaningful Activity' services will assess their 25hr a week activity plans and recording systems against this definition.<br>Indicator – Provider to submit feedback report<br>Q2. Services will audit their services using the national agreed bench marking tool<br>Indicator – Provider to submit audit Report<br>Q3. Services will develop a work plan to address needs identified in Audit Report<br>Indicator – Provider to submit work plan<br>Q4. Services will implement their work plan<br>Indicator – Provider to submit update report on work plan implementation | Quarterly |

| Table 12 Continued | | | | |
|---|---|---|---|---|
| **Goal number & Quality domain (weighting)** | **Description of Goal** | **Description of Indicator number/name** | **Description of Information Requirement** | **Payment Period** |
| 5. A) Involvement Choice & Responsibility<br><br>B) Whole dining Experience<br><br>(25%) | The CQUIN promotes the notion of service users and care staff working in real partnership in order that service users can move through a shared pathway in a timely manner. It is assumed that in doing so length of stay can be reduced and the experience of care improved. | This CQUIN aims to help prepare services to build on and develop strong involvement infrastructure which will assist in implementing the national QIPP work stream in relation to improving the quality of the pathway within services. Its aim is to develop a shared understanding of the pathway between service users and staff, where service users take an increasing role in meeting outcomes, and responsibility in relation to choice and lifestyle | Q1. Services will identify service user and staff involvement leads whose roles are to involve service users and staff to work jointly and introduce, discuss, and understand the underpinning objectives of the Shared Pathway QIPP work stream.<br>Indicator – Provider to submit joint staff/service user report outlining process and feedback | Quarterly |
| | | | Q2. Staff and service user leads will involve service users and staff in discussing, thinking about and understanding the proposed outline of the Shared Pathway. This will include specific areas around choice, lifestyle and responsibility.<br>Indicator – Provider to submit joint staff/service user report outlining feedback | |
| | | | Q3. Staff and service user leads will jointly identify priorities that services need to develop to be able to deliver on the Shared Pathway.<br>Indicator – Provider to submit implementation Plan | |
| | | | Q4. Staff and service users will jointly develop a work plan which outlines the underpinning work required to implement the Shared Pathway in 2012/13, including milestones, outcomes and timeframes<br>Indicator – Provider to submit implementation Plan | |
| | Service providers will meet the standards outlined in the "Whole Dining Experience Audit Report". | This CQUIN builds on work done in 2010-2011 to respond to the issues outlined in the 'Whole Dining Experience' audit. By the end of contract year 2011-2012 Service providers will meet all four of the standards outlined in the "Whole Dining Experience Audit Report". | Q1. Providers will submit an update report to demonstrate how they will meet all four standards contained within the 'Whole Dining Experience' report by the end of quarter 4 | |
| | | | Q2. 'Whole Dining Experience' Update report | |
| | | | Q3. 'Whole Dining Experience' Update report | |
| | | | Q4. 'Whole Dining Experience' Final update report | |
| 6. Recovery Planning<br>(25%) | The CQUIN promotes the notion of service users and care staff working in real partnership in order that service users and care staff can work to a shared understanding of recovery. It is assumed that in doing so length of stay can be reduced and the experience of care improved. | This CQUIN aims to help prepare services to build on and develop strong recovery planning processes which will assist in implementing the national QIPP work stream in relation to improving the quality of the pathway within services. Providers will continue to use and develop joint working and a shared understanding of recovery. | Q1. Services to identify service user and staff recovery leads that will organise a workshop/group within their unit to share and explore learning from the use of recovery tools and approaches from 2010/11. From this group they will identify key areas for development.<br>Indicator – Provider to submit joint service user/staff report on key areas for development and joint work pl | Quarterly |
| | | | Q2. Implement joint work programme<br>Indicator – Provider to submit update report on progress | |
| | | | Q3. Service user and staff recovery leads to introduce discuss and understand with service users and staff the priority areas of development as identified within the Shared Pathway QIPP work stream.<br>Indicator – Provider to submit joint service user/staff feedback Report | |
| | | | Q4. Service user and staff recovery leads to develop a joint service user/staff underpinning service development programme which will support the introduction of the Shared Pathway in relation to recovery for the following year.<br>Indicator – Provider to submit joint development programme with milestones and timeframes. | |

## 2.2.5 What others say about the Trust

### 2.2.5 (i) Care Quality Commission (CQC)

South West Yorkshire Partnership NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered with no compliance conditions.

The Care Quality Commission has not taken enforcement action against South West Yorkshire Partnership NHS Foundation Trust during 2010/11.

South West Yorkshire Partnership NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

There has been no planned CQC review within the year and CQC was not required to publish performance against indicators taken out of the NHS operating framework for 2010/11. The Trust has not self-assessed any significant lapse against the CQC quality regulations in 2010/11.

The Trust did participate in a multi-agency pilot study regarding assessment/decisions to detain under the Mental Health Act. Feedback from the Care Quality Commission (CQC) has been very positive with identified notable good practice areas including: overall knowledge of MHA and Code of Practice; MHA administrative support; Interagency collaboration on training; Use of section 136 suites at Fieldhead and the Dales. Issues identified as requiring attention (from all partners) include: access to beds to ensure timely admission and assessment; delays in patients taken to 136 suites; advanced statements not taken into account in decision making prior to detention; agreed strategy for further training and employment of Approved Mental Health Professionals (AMHPs).

The CQC use Quality & Risk Profiles (QRPs) to monitor trusts' compliance with the essential standards of quality and safety. The QRP combines both quantitative (numerical) and qualitative (textual) information. CQC inspectors will use QRPs when:

- Carrying out a planned review of compliance, to identify and prioritise potential risks of non-compliance
- To regularly review potential non-compliance which may trigger a responsive review of compliance

The QRP scoring delineates the ratings into a 4 part scale. Green and Neutral which are 'reducing risk of non-compliance' and Amber and Red which are 'increasing risk of non-compliance'. Throughout the period that the QRPs have been in operation all the trust's summary ratings have remained green or neutral.

The Trust has participated in the CQC annual service user survey which involved 66 NHS trusts in England (including combined mental health and social care trusts, Foundation Trusts and primary care trusts that provide mental health services). Service users aged 16 and over were eligible for the survey if they were receiving specialist care or treatment for a mental health condition and had been seen by the Trust between 1 July 2009 and 30 September 2009. For each question in the survey, individual responses are converted into scores on a scale of 0 to 100. A score of 100 represents the best possible response. Therefore, the higher the score for each question, the better the trust is performing. (The scores are not percentages, so a score of

80 does not mean that 80% of people who have used services in the trust have had a particular experience). The CQC converts this into scores out of 10 for each survey section. Benchmarking indicates whether the trust's score on each individual question places it in the top 20%, middle 60% or bottom 20% of all trusts.

**Table 13: CQC community service user survey 2010**

| Section heading | Score out of 10 for the Trust | How this score compares with other Trusts |
|---|---|---|
| Health and Social Care Workers | 8.76 | About the same |
| Care Coordinator | 8.55 | About the same |
| Care Review | 7.42 | About the same |
| Medications | 7.3 | About the same |
| Talking therapies | 7.27 | About the same |
| Care Plan | 6.58 | About the same |
| Day to Day Living | 5.9 | About the same |
| Crisis Care | 5.89 | About the same |
| Overall | 6.86 | About the same |

**Table 14: CQC community service user survey - highest/lowest scoring questions**

| Top scoring questions | | Lowest scoring questions | |
|---|---|---|---|
| (Scores out of 100) | | | |
| Did this person treat you with respect and dignity? | 95 | Do you understand what is in your care plan? | 64 |
| Did this person listen carefully to you? | 88 | Does your care plan set out your goals? | 63 |
| Can you contact your care co-ordinator if you have a problem? | 88 | Does your care plan cover what you should do if you have a crisis? | 63 |
| Did this person take your views into account? | 86 | Have you been given (or offered) a written or printed copy of your care plan? | 61 |
| Did you have trust and confidence in this person? | 86 | Were you told about possible side effects of the medications? | 57 |
| How well does your care co-ordinator organise the care & services you need? | 86 | The last time you called the (out of office hours) number, did you get the help you wanted? | 55 |
| Were the purposes of the medications explained to you? | 84 | Does anyone in MH services give you enough support getting help for any physical health needs? | 51 |
| Were you given enough time to discuss your condition and treatment? | 83 | Does anyone in MH services ask you about any physical health needs you might have? | 48 |
| Do you know who your care co-ordinator is? | 82 | have the number of someone from your local NHS Mental Health Service that you can phone out of office hours? | 45 |
| Were you given a chance to express your views at the (care review) meeting? | 82 | Did mental health services give you enough support with your care responsibilities? | 34 |

The Trust has also participated in the CQC annual staff survey. 416 staff participated giving a response rate of 54% (average for mental health/learning disability trusts in England).

**Table 15: CQC annual staff survey 2010**

| Indicator | Score (range = 1-5) | How this score compares with other Trusts |
|---|---|---|
| Overall indicator – Staff Engagement | 3.69 | Above (better than) average when compared with trusts of a similar type |
| **Four key Findings for which South West Yorkshire Partnership NHS Foundation Trust compares most favourably with other mental health/learning disability trusts in England.** | | |
| Staff intention to leave jobs<br>Work pressure felt by staff<br>% staff reporting errors, near misses or incidents witnessed in the last month<br>% staff receiving job-relevant training, learning or development in last 12 months | | |
| **Four key Findings for which South West Yorkshire Partnership NHS Foundation Trust compares least favourably with other mental health/learning disability trusts in England.** | | |
| Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months<br>Percentage of staff having equality and diversity training in last 12 months<br>Support from immediate managers: Impact of health and well-being on ability to perform work or daily activities | | |
| **Three key Findings where staff experiences have improved since the 2009 survey.** | | |
| Percentage of staff appraised in last 12 months<br>Percentage of staff appraised with personal development plans in last 12 months<br>Percentage of staff having well structured appraisals in last 12 months | | |
| **Two key Findings where staff experience has deteriorated since the 2009 survey.** | | |
| Trust commitment to work-life balance<br>Support from immediate managers | | |

## 2.2.6 Data quality

### 2.2.6 (i) Actions

**South West Yorkshire Partnership NHS Foundation Trust will be taking the following actions to improve data quality**

Service user care and safety depends on good quality data. Poor quality data can impact on care, damage the reputation of the organisation and individuals, lead to flawed clinical/care, administrative and planning decisions and disrupt funding.

The importance of data for NHS bodies and the patients and public they service has never been higher. Improving data quality is one of the national priorities outlined in the 2010/11 operating framework and is an essential component to successful delivery of the mental health and learning disability contract. There is increased accountability through the Quality Accounts, through Commissioning for Quality and Innovation (CQUIN) and ultimately through the requirement to have accurate activity and costing data to underpin Payment by Results (PbR).

Good data quality is a key element in the Information Governance toolkit and to meeting the requirements of external compliance and performance frameworks.

Improving data quality is a key priority of the Trust. Clinical engagement and ownership is fundamental to high quality data and it is essential to implement clinician validation and to develop information and data that meets the requirements and needs of clinicians to enable them to lead the drive to improve data quality. Ensuring frontline staff, clinicians and data entry staff are engaged and understand the implications of poor data is the key to embedding data quality into organisational practice.

- Data collected as part of clinical/care activity is recorded on the Trust's clinical information system (RiO) as the electronic patient health record. Clinical data used to support clinical and business activity will continue to be derived directly from the operational care record.

- In line with best practice, the Trust implemented the Audit Commission's Information Assurance (IA) Framework in February 2010. The Audit Commission describe the requirements for robust data assurance as clear leadership, greater clinical engagement, stronger interest from Boards, external monitoring and review and more central support. Progress against the IA framework will continue to be performance managed through the Executive Management Team (EMT) and Trust Board.

- Trust Board has overall accountability with responsibility for data quality devolved to EMT. Individual director responsibility is actioned through the Information Governance Trust Action Group (TAG) and the IM&T TAG.

- The quality of data on RiO has been reviewed though an annual audit process since 2008/9 and continues to achieve significant assurance levels. Implementation of the action plans are monitored by the Trust Audit Committee. The Quality Account was audited by Grant Thornton in July 2009, who also reported that the Trust was likely to attain reasonable assurance on the 2011/12 Quality Report.

- The performance management of data quality has been significantly strengthened in 2010/11 with the development of the Business Delivery Units (BDUs) and the BDU performance management structures & processes that have been put in place. Data against a balanced score card of Key Performance Indicators (KPIs) is reviewed monthly and action initiated to address issues as appropriate. These meetings are chaired by the BDU Directors, attended by the head of service and general managers of the service lines and supported by representatives from corporate support services.

- A high level RiO data quality plan and a specific RiO Medics data quality plan are being actioned through the delivery of the Trust Change Management Programme, by BDUs and by the RiO Medics Data Quality Group. Action plans were developed based on the self assessment against the Audit Commission Information Assurance Framework in February 2010 and with reference to internal and external data quality requirements.

- Data quality is reported to EMT and to Trust Board through the Strategic Overview performance report via a number of Key Performance Indicators (KPIs) and a monthly analysis of performance against key internal and external targets. The Information Governance TAG receives bi-annual data quality reports that review a number of aspects of data quality for a range of key performance indicators.

- The roles and responsibilities of clinical staff, data input staff and service managers are described in detail in the Trust Data Quality Policy. Clinical staff have access to a number of data quality reports developed to run directly from the RiO clinical information system. These reports provide an instant view of missing key data items and provide hyperlinks for staff to the area in RiO where any amendments/inputs can be entered.

- The Performance & Information (P&I) team scan, interpret, disseminate and respond to data/data quality standards and requirements, ensure RiO supports robust data collection & reporting and ensure all internal and external returns and data sets are submitted to required standards and to meet agreed deadlines. P&I have lead responsibility for delivering the Trust Performance Management Framework.

- The importance of data quality is communicated widely throughout the organisation including through the Induction process, RiO training, Team Brief, Extended EMT, BDU performance meetings, the Intranet & performance reports. Communications include the development of Ten top things to do on RiO, Ten top things to do on RiO (Medical staff) & RiO data quality posters. RiO pens and a RiO stars project are being progressed.

- Data quality is embedded within the Trust risk management arrangements with significant risks incorporated within the hierarchy of organisational risk logs.

- The organisation continues to make good progress with respect to data quality assurance through the delivery of the Trust Data Quality Strategy and associated data quality action plan.

### 2.2.6 (ii) NHS number and medical practice code validity

South West Yorkshire Partnership NHS Foundation Trust submitted records during 2010/11 to the secondary uses service for inclusion in the hospital episode statistics which are included in the latest published data:

Which included the patient's valid NHS number was:
- 99.9% for admitted patient care (99.8% in 2009/10)

*Percentages for out patient care and accident and emergency care – Not Applicable*

Which included the patient's valid Medical Practice Code was:
- 99.7% for admitted patient care (99.5% in 2009/10)

*Percentages for out patient care and accident and emergency care – Not Applicable*

### 2.2.6 (iii) information governance toolkit attainment levels

South West Yorkshire Partnership NHS Foundation Trust's Information governance assessment report score overall score for 2010/2011 was 80% and was graded red.

### 2.2.6 (iv) Clinical Coding error rate

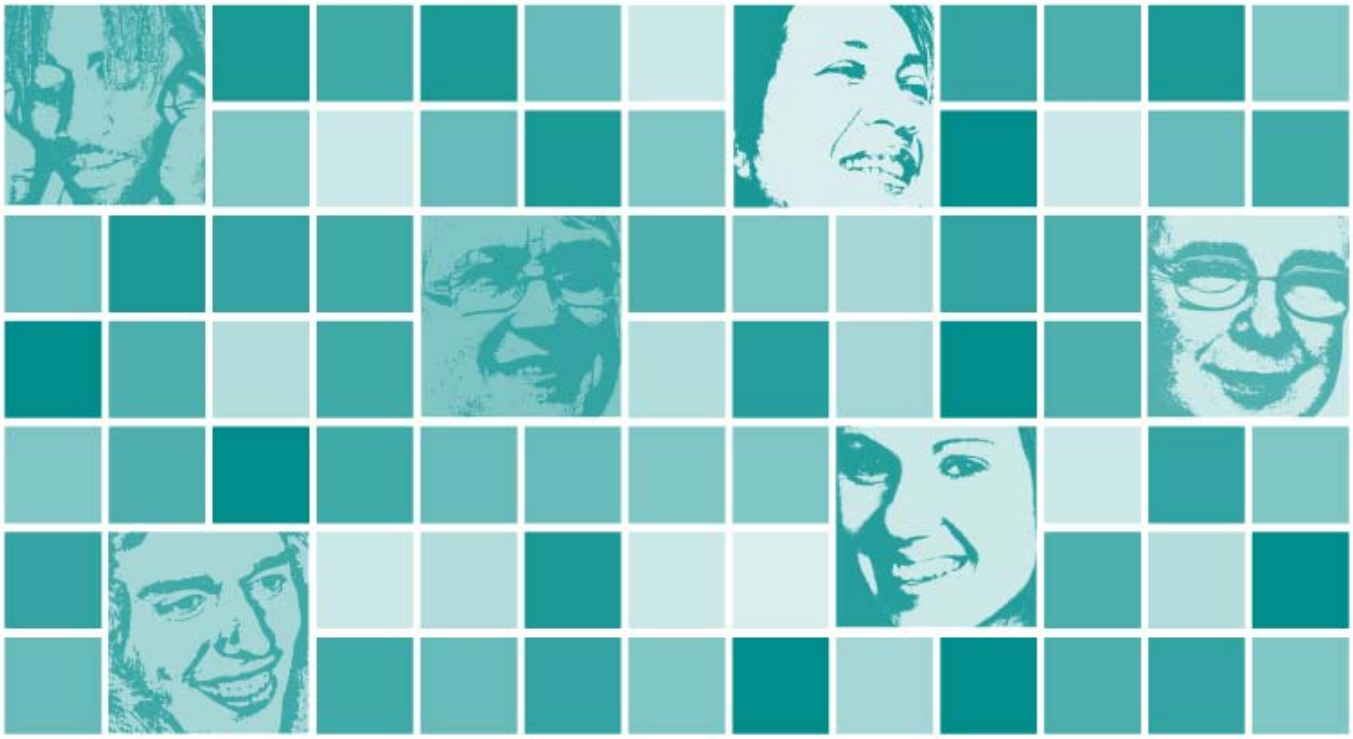
South West Yorkshire Partnership NHS Foundation Trust was subject to the payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

Primary Diagnoses Incorrect – 10%
Secondary Diagnoses Incorrect – 15%
Primary Procedures Incorrect – 100%
Secondary Procedures Incorrect – 100%

The results should not be extrapolated further than the actual sample audited. The following services were reviewed within the sample: inpatients across all sites (forensic, adults of working age, people with a learning disability, older people).

***See previous pages 59-60 for information on action taken to improve data quality.***

# Part 3



# 3.1 Review of quality performance

### 3.1.1 Quality Performance 2010/2011

Within this part of the report we present data relevant to local stakeholders (people who take an interest in the Trust). This information relates to locally determined quality priorities and indicators.

As a result of stakeholder engagement we determined to roll forward the quality priority themes identified in the first year we produced a Quality Report (2008/09) as these still represented key areas of challenge. Throughout the year we have continued to progress work against these 5 themes -

- Mutual respect
- Personalised care
- Improving practice and positive outcomes
- Environment and hotel services
- Suicide prevention and risk management

- via implementation of our quality plan. Some of the main aspects being:

- Development of a Quality Academy to bring support services together and revise their “offer” to Business Delivery Units, ensuring that all services are focussed on adding value to the people who are in our care impacting on improving practice and positive outcomes.
- Implementation of the Productive Mental Health Ward has led to inpatient facilities focussing on how they can release time to care by reducing activities that do not add value to patient care.
- Further developing the Care Programme Approach (CPA) and implementing the CPA strategy so that people received personalised care plans that impact on them achieving positive outcomes.
- Reviewing the environment and reducing risk by moving services off St Luke’s Hospital site to more appropriate accommodation in the Kirklees and Calderdale areas.
- Implementing real-time patient feedback kiosks in in-patient wards so that service changes can be made to support improved patient experience.
- Developing an incident review committee to support learning from serious incidents in order to implement change to prevent further incidents occurring.

In Part 1 of this report there is descriptive detail of examples of service interventions and innovations implemented by the Trust in 2010/11 against the three quality domains. In this section we focus on performance against national and local quality indicators.

### 3.1.1 (i) Monitor Assessed National Targets

The Trust Board is required to confirm that appropriate governance arrangements are in place. The Trust has retained a governance risk assessment of green throughout 2010/11. The Trust has had to confirm compliance with authorisation in relation to the healthcare targets and indicators listed below.

**Table 16: National targets 2009/2010 and 2010/2011**

| Assessed by Monitor | | Results | |
|---|---|---|---|
| **Target** | **10/11 Threshold** | **09/10** | **10/11** |
| CPA patients<br>• receiving follow up contact within 7 days of discharge<br>• having formal review within 12 months | <br>95%<br>95% | <br>97.4%<br>N/A | <br>96.8%<br>97.6% |
| Minimising delayed transfers of care | <=7.5% | 3.1% | 2.8% |
| Admissions to inpatient services had access to crisis resolution home treatment teams | 90% | 95.2% | 96.2% |
| Meeting commitment to serve new psychosis cases by early intervention teams | 95% | 229.7% | 169.3% |
| Data completeness: identifiers | 99% | N/A | 98.5% |
| Data completeness: outcomes | 50% | N/A* | 63.5% |

** re: "Data completeness:outcomes" – no 2009/10 performance figure shown as the measure changed to contain 7 elements for 2010/11 as opposed to 8 for 2009/10. The figure for 2009/10 was 57.5%.*

Delivering care that meets Care Quality Commission regulatory requirements is also an important indicator of service quality. This information is reported in Part 2 (p.55-57).

### 3.1.1 (ii) Local Indicators

The trust specified a number of indicators against the 5 priority areas and three quality domains – safety, service user experience and effectiveness. The underlying reason for the choice of each indicator is described and where possible historical and benchmarked data is referenced. The data within this section has been shared and reviewed by a group of clinicians in order to test the reliability and validity of the reported results. There is specific information relating to performance against the indicators used in the 2009/10 account and where there has been a change to the indicators used the reasons for change have been given.

Some of our local indicators relate to service user survey data. We recognise that there is generally some time lag between people receiving a service, being asked to participate in a survey and then the survey results being published. Therefore in 2011/12 we will have procured service user feedback kiosks on all units to enable more real time collation and reporting of service user and carer views.

Commissioning for Quality and Innovation (CQUIN) makes a portion of a provider's income conditional on quality and innovation. CQUIN indicators are important aspects of a quality plan as they represent what the commissioners have identified as demonstrating quality according to local needs. However as CQUINs have been identified and reported in Part 2 (pp.47-54) they are not repeated in this section of the report.

**Table 17: How the local quality indicators relate to the three quality domains**

| Indicator | Related Domain | | |
|---|---|---|---|
| | Safety | Experience | Effectiveness |
| Complaints with staff attitude as an issue | | ■ | |
| CQC national community service user survey criteria related to dignity & respect. | | ■ | |
| Benchmarked (33 participating Trusts) Inpatient Survey Criteria related to dignity & respect – 'yes definitely' scores | | ■ | |
| Service users on new CPA being offered or given a copy of their care plan | | | ■ |
| CQC national community service user survey criteria related to care planning | | ■ | |
| Trust-wide CPA audit criteria | ■ | ■ | ■ |
| Service user survey criteria related to positive experience | | ■ | |
| Compliance with National Institute for Health & Clinical Excellence (NICE) standards | | | ■ |
| Staff receiving appraisal (in last 12 months?) | | | ■ |
| Implementation of integrated packages of care | | | ■ |
| Eliminating mixed sex accommodation | | ■ | |
| Hygiene code criterion 2 - provide & maintain a clean and appropriate environment | ■ | ■ | ■ |
| Good quality general environment, food and privacy & dignity (PEAT Audits & Unannounced visits) | ■ | ■ | ■ |
| All staff working in health care settings have awareness and knowledge of who to report safeguarding children issues to. | ■ | | ■ |
| All service users have a clinical risk assessment | ■ | ■ | ■ |
| Prevention of deaths within most preventable high risk groups from national confidential inquiry into suicide and homicide | ■ | | ■ |

## 3.1.2 Priority area - mutual respect between service users and teams/ individuals

**Rationale for indicators inclusion**

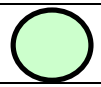
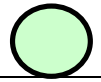
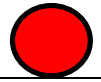
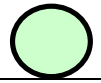
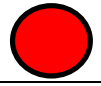
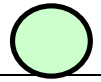
To improve the quality of services it is important to understand what people who receive our care feel about their treatment. Staff attitudes and behaviours consistently feature as one of the most important aspects of care in feedback from service users and carers. Complaints and national and local service user experience survey results can be used to identify and target areas for improved performance.

| Local quality indicator | Construction | Minimum target 10/11 | Performance 09/10 | Performance 10/11 | Achieved 10/11 |
|---|---|---|---|---|---|
| **Complaints with staff attitude as an issue** | % average across 12 months | < 30% | 21% | 14% |  |
| ***Domain – service user experience*** | | | | | |
| **CQC national community service user survey criteria related to dignity & respect.** | Treated with respect and dignity by health and social care worker | Top 20%<br>≥ 94 | National CQC survey not conducted in 09/10 | Score = 95 |  |
| ***Domain – service user experience*** | | | | | |
| **Benchmarked (33 participating Trusts) Inpatient Survey Criteria related to dignity & respect – 'yes definitely' scores** | Did the psychiatrist treat you with respect & dignity? YES ALWAYS | Score within top half of all Trust scores (≥70%) | Scoring not comparable with National CQC survey conducted in 09/10 | 66% |  |
| | Did the nurses treat you with respect & dignity? YES ALWAYS | Score within top half of all Trust scores (≥61%) | | 61% |  |
| ***Domain – service user experience*** | | | | | |

## 3.1.3 Priority area – personalised care

**Rationale for indicators inclusion**

Care planning is a fundamental aspect of care within mental health and learning disability services. Service users should feel they have been fully engaged in care planning, that it is a beneficial process and should be offered a copy of the care plan to support their full involvement. Care planning should be properly recorded and include critical aspects to ensure an appropriate service response to service user needs.

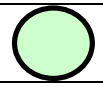
| Local quality indicator | Construction | Minimum target 10/11 | Performance 09/10 | Performance 10/11 | Achieved 10/11 |
|---|---|---|---|---|---|
| **Service users on new CPA recorded as being offered or given a copy of their care plan** | % of all those on new CPA recorded on the electronic information system as being offered a copy of their care plan | 80% | Month 12 85% | Month 12 82% *(Target achieved every month throughout 10/11)* |  |
| ***Domain – effectiveness*** | | | | | |
| **CQC national community service user survey criteria related to care planning** | Do you know who your care co-ordinator is? | Top 20% ≥ 87 ≥ 87 ≥ 75 | National CQC survey not conducted in 09/10 | Score 82 (middle 60%) |  |
| | Can contact care coordinator if have a problem | | | Score 88 (top 20%) |  |
| | Did you find the care review helpful? | | | Score 74 (middle 60%) |  |
| ***Domain – service user experience*** | | | | | |
| **Trust-wide CPA audit criteria (audit completed March 11)** | Electronic case records (n= 914 ) completed: Care plan; Relapse indicators; Contingency plan; Crisis plan; [1]24/7 contact details | ≥ 75 | Achieved | All 5 criteria above 75% |  |
| | Electronic case records (n= 914 ) Care plan identifies: Needs/ aspirations; How these are addressed; Desired outcomes | ≥ 75 | Achieved | 1/3 criteria above 75% *(interventions – 66% & outcomes 65%)* |  |
| | Service user survey (n =53) Have a care plan; agreed the care plan; fully involved in production of the care plan; care plan identifies what is expected from me; how other people support me; what services/support will be provided. | ≥ 75 | Achieved 09/10 50% target | All criteria above 75% |  |
| | Carer survey (n = 37) Been involved in (service user's) care plan; reviewing their care; able to identify and discuss risks. | ≥ 75 | Achieved 09/10 50% target | All criteria above 75% |  |
| ***Domain – safety, effectiveness and service user experience*** | | | | | |

[1] Forensic services excluded in '24/7 contact details' – all other CPA criteria includes adult, older people and forensic services

## 3.1.4 Priority area - improving practice and positive outcomes for service users

**Rationale for indicators inclusion**

The Trust must respond to national regulator findings such as the CQC who have stated that too great a proportion of service users feel let down in important aspects of care such as feeling safe on the ward. Effectiveness may be demonstrated by compliance with national standards (such as NICE). Workforce development is recognised as critical in underpinning good practice.

| Local quality indicator | Construction | Minimum target 10/11 | Performance 09/10 | Performance 10/11 | Achieved 10/11 |
|---|---|---|---|---|---|
| **Service user survey criteria related to positive experience** | CQC national Community Survey - overall, how would you rate the care you have received from mental health services in the last 12 months | Top 20%<br>≥ 73 | National CQC survey not conducted in 09/10 | Score 73 |  |
| | Benchmarked Inpatient Survey - overall, how would you rate the care you received during your recent stay in hospital - EXCELLENT | Score within top half of all Trust scores<br>(≥ 19%) | Scoring not comparable with National CQC survey conducted in 09/10 | 23% |  |
| | Benchmarked Inpatient Survey During your most recent stay were there enough activities available:<br>ALL OF THE TIME<br>during the day on weekdays<br>during evenings and weekends? | Score within top half of all Trust scores<br>(≥ 22% & 12%) | | 30% & 22% |  |
| | Benchmarked Inpatient Survey During your most recent stay did you feel safe? YES ALWAYS | Score within top half of all Trust scores<br>(≥ 44%) | | 44% |  |
| ***Domain – service user experience*** | | | | | |
| **Compliance with National Institute for Health & Clinical Excellence (NICE) standards** | Achieve all 4 criteria: All relevant guidance placed with lead group for initial review/implementation within 4 weeks of publication; Quarterly compliance & risk updates received for all relevant guidance; No 'red' internal risk gradings (relating to compliance & action plan status); No 'amber' internal risk grading reported for same piece of guidance for a 3rd consecutive quarter. | 100% | 100% | 100% |  |
| ***Domain – effectiveness*** | | | | | |
| **Staff receiving appraisal (in last 12 months)** | % of staff who have had an appraisal in last 12 months | > 80% | Average 09/10 80% | 81.5% |  |
| ***Domain – effectiveness*** | | | | | |
| **Implementation of integrated packages of care** | % of service users assessed using the integrated packages approach to care assessment | 50% | 80.7% | 73.0% |  |
| ***Domain – effectiveness*** | | | | | |

## 3.1.5 Priority area - environment and hotel services

**Rationale for indicators inclusion**

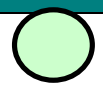
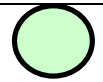
Service users should be seen in safe, accessible surroundings that promote their well being (CQC regulation 15) This encompasses national priorities such as the elimination of mixed sex accommodation and effective infection prevention and control. Service users in inpatient areas are at increased risk of contracting an HCAI due to potential exposure to infections in other service users, staff and visitors. Compliance with the food safety act requires that food handling areas are thoroughly inspected. Having a choice of good quality food at mealtimes encourages people to eat and lessens the risk of malnourishment/ poor diet.

| Local quality indicator | Construction | Minimum target 10/11 | Performance 09/10 | Performance10/11 | Achieved 10/11 |
|---|---|---|---|---|---|
| **Eliminating mixed sex accommodation** | Provision of designated sleeping accommodation for men and women | 100% | 100% | The Trust is 100% compliant in providing designated sleeping accommodation for men and women. |  |
| ***Domain – service user experience*** | | | | | |
| **Hygiene code criterion 2 - provide & maintain a clean and appropriate environment which facilitates prevention and control of HCAI** | Hygiene criteria scores from all internal & external PEAT audits throughout the year.<br><br>The scoring range for PEAT audits is 0 (unacceptable) to 5 (excellent). | To maintain a mean PEAT score of 4/5. | Mean score of 4/5. | Mean score of 4/5.<br><br>*(note – improvement in many individual scores from 4 to 5 from 09/10)* |  |
| ***Domain – safety, effectiveness and service user experience*** | | | | | |
| **Good quality general environment, food and privacy & dignity** | 'Excellent' PEAT scores reported by National Patient Agency re: General environment, food and privacy & dignity | Achieving Excellent or Good for all units assessed (11). | 100% | Internal assessment by PEAT Team = 100% but official rating not received until June/July 2011 |  |
| | Peat audits - Average food safety scores | Average scores for all units > 70% | 100% | 91% as at end Feb |  |
| | Choice of Food at Main Meal – internal and external PEAT scores | 100% | 100% | 100% |  |
| | Unannounced monitoring visits Quality of Food acceptability scores (re: appearance, smell, taste, texture) | All units to score above 70% | 100% | 80% |  |
| ***Domain – safety, effectiveness and service user experience*** | | | | | |

## 3.1.6 Priority area - suicide prevention and risk management

**Rationale for indicators inclusion**

Staff must comply with safeguarding procedures and reporting. A key requirement is compliance with the statutory guidance "Working Together to Safeguard Children". Staff should have a clear understanding of abuse, local procedures of reporting and where to access further guidance/support. Individual clinical risk assessment is a critical factor in suicide prevention. Learning from the national confidential inquiry into suicide and homicide is that effective management of high risk factors can prevent deaths. People who abscond or who have recently transferred from inpatient units back into the community can be particularly vulnerable and at risk of attempting suicide. (Anyone on CPA who is discharged should be contacted within 7 days).

| Local quality indicator | Construction | Minimum target | Performance 09/10 | Performance 10/11 | Achieved 10/11 |
|---|---|---|---|---|---|
| **All staff working in health care settings (clinical and non-clinical) have awareness and knowledge of who to report safeguarding children issues to.** | • Completion of annual section 11 (Children Act) for 3 safeguarding boards) | Declared compliant | Compliant | Compliant |  |
| | • Training – all staff to have level 1 induction training | ≥70% | 100% | 100% |  |
| | • All clinical staff to receive level 2 training on 3 year rolling programme | ≥70% | 80% | 74.4% |  |
| ***Domain – safety and effectiveness*** | | | | | |
| **All service users have a clinical risk assessment** | Trust-wide CPA audit (n = 914) Sainsbury Level 1 Risk assessment or HCR 20 (Forensic Services) Recorded | 80% across all care groups | All care groups >80% | 89% |  |
| | Trust-wide CPA audit – (n = 914) Sainsbury level 1 risk assessment completed /updated in last 12 months | 80% across all care groups | 53% adult 66% older Forensic not included | 55% |  |
| | Qualified clinical staff to receive training on the LD initial and comprehensive risk assessment being implemented across Level 2 LD Specialist Services ( level 2 = Inpatient and Community Assessment & Treatment ) | 80% uptake - training on initial assessment<br>50% uptake- training Comprehensive assessment | N/A | 80%<br>80% |  |
| ***Domain – safety, effectiveness and service user experience*** | | | | | |
| **Prevention of deaths within most preventable high risk groups identified from the national confidential inquiry into suicide and homicide** | Annual undetermined deaths audit Number of deaths of people who had absconded from an inpatient ward. | 0 | 0 | 1 |  |
| | Annual undetermined deaths audit Number of deaths of people within 1 week of discharge. | 0 | 0 | 0 |  |
| ***Domain – safety and effectiveness*** | | | | | |

## 3.1.7 Local Quality Indicators Not Achieved

Table 18 lists the local indicator criteria where we failed to achieve the targets and indicates improvement action being taken.

**Table 18: Targets Not Achieved**

| Indicator criterion | Data Source | Target | Performance | Improvement Action |
|---|---|---|---|---|
| Did the psychiatrist treat you with respect & dignity? YES ALWAYS | Benchmarked (33 participating Trusts) Inpatient Survey | Score within top half of all Trust scores (≥70%) | 66% | • Survey results reviewed by the Medical staff Committee.<br>• All medical staff made aware of findings.<br>• Treating people with respect and dignity is built into annual appraisal processes (including 360 degree feedback). |
| Did you find the care review helpful? | CQC national community service user survey criteria related to care planning | Top 20% ≥ 75 | Score 74 (middle 60%) | (In the 2010-11 Trust CPA Audit the same question was asked with the following results: people on CPA 86%, people on Standard Care 57%, total 79%)<br>• Recent changes to the recording of CPA reviews supported by training has strengthened the requirement for individuals to be fully engaged and involved in their reviews. The Trust will continue to deliver a CPA training programme which emphasises the purpose and importance of the review.<br>• The incorporation of the Recovery Star as an outcome measurement tool for the individual within the review process will strengthen the meaning and purpose of a review for the individual.<br>• The Trust will continue to offer service users and their carers information and advice relating to CPA and review processes including the distribution of the recently produced information booklet. |
| Care plan identifies: Needs/ aspirations; How these are addressed; Desired outcomes | Trust-wide CPA audit criteria Electronic case records (n= 914 ) | ≥ 75% | 2 of the three criteria fell below 75% | • Continued delivery of CPA training emphasising the requirements of effective care planning.<br>• Monitoring - Audit of the quality of care plans identified in the 2011-12 audit plan. |
| Sainsbury level 1 risk assessment completed /updated in last 12 months | Trust-wide CPA audit criteria Electronic case records (n= 914 ) | 80% across all care groups | 55% | • Business Delivery Units have implemented action plans in response to the audit findings.<br>• Continued delivery of training in relation to the requirements of risk assessment with an emphasis on documentation reviews.<br>• The indicator is to be reviewed in light of the different risk tools available and their relationship to review processes. The risk assessment undertaken should use the most effective tool for the individual. |
| Number of deaths of people who had absconded from an inpatient ward. | Annual undetermined deaths audit | 0 | 1 | • The Trust now has an organisational suicide prevention strategy.<br>• There is controlled access and egress to all bed based units with continuous monitoring. |

## 3.1.8 Quality indicators which were reported in the Trust's 09/10 quality report

**Table 19: Indicators Reported in 09/10**

| Domain | Indicator | Where reported in the 10/11 account | If not reported – reason why |
|---|---|---|---|
| **Safety** | Hygiene code criterion 2 – provide and maintain a clean and appropriate environment which facilitates prevention and control of HCAI | Part 3 | |
| | All service users have a clinical risk assessment | Part 3 | |
| | All staff working in healthcare settings have awareness and knowledge of who to report safeguarding children issues to | Part 3 | |
| | Prevention of deaths within most preventable high risk groups identified from the national confidential inquiry into suicide and homicide | Part 3 | |
| **Effectiveness** | Service users on new CPA recorded as offered or given a copy of their care plan | Part 3 | |
| | Compliance with National Institute for Health & Clinical Excellence (NICE) standards | Part 3 | |
| | Staff receiving appraisal within last 12 months | Part 3 | |
| | Implementation of integrated packages of care | Part 3 | |
| **Experience** | Complaints upheld with staff attitude as an issue | Part 3 | |
| | Annual Community service user (local) survey criteria related to dignity & respect | (Part 3) Replaced by National CQC Community Survey | Scoring of 09/10 local survey not directly comparable with National CQC survey scoring |
| | Annual Community service user (local) survey criteria related to positive experience | (Part 3) Replaced by National CQC Community Survey | Scoring of 09/10 local survey not directly comparable with National CQC survey scoring |
| | National CQC inpatient survey criteria related to dignity & respect | (Part 3) Replaced by benchmarked survey involving a number of Trusts | National CQC survey not conducted in 10/11 - scoring of local survey not directly comparable with 09/10 national CQC survey scoring |
| | National CQC inpatient survey criteria related to care planning | (Part 3) Replaced by benchmarked survey involving a number of Trusts | National CQC survey not conducted in 10/11 - scoring of local survey not directly comparable with 09/10 national CQC survey scoring |
| | Eliminating Mixed Sex Accommodation | Part 3 | |
| | Trust-wide CPA audit criteria | Part 3 | |
| | Good quality general environment, food and privacy & dignity | Part 3 | |
| **Key national priorities** | National targets – reported to CQC | Not reported | No longer part of CQC assessment |
| | National targets – reported to Monitor | Part 3 | |
| **CQUINs** | Regional, local and forensic | Part 2 | |

# 3.2 Statements from Local Involvement Networks, Overview and Scrutiny Committees and Primary Care Trusts

## 3.2.1 Primary Care Trust Statement to South West Yorkshire Partnership NHS Foundation Trust's Quality Accounts 2010/11

The following statement is presented on behalf of commissioning partners from NHS Kirklees, NHS Wakefield district and NHS Calderdale.

The published account is a comprehensive and detailed assessment of quality in 2010/11, and highlights South West Yorkshire Partnership NHS Foundation Trust's (SWYPFT) priorities and ongoing commitment to quality going forward into 2011/12.

To the best of our knowledge, through contract monitoring, quality board and the mental health partnerships across the geographical patch, the information provided is accurate and has been fairly interpreted, reflecting the ongoing dialogue with commissioners.

Commissioners feel that the report is generally strong on effectiveness, patient experience, safety, outcomes and achieved a balance between what's going well and what needs to be improved. However, the document includes details of a number of areas where performance or compliance is below average, and it is disappointing that there is no supplementary information or links to other relevant sections of the document to show how the Trust is proactively addressing these areas to stimulate improvement. This includes actions taken following the national inpatient and community mental health patient surveys (pgs.11, 26, 56); improving safeguarding adults abuse awareness training (pg. 27) and the information governance toolkit score (pg. 61).

Assurance is given that the priorities for improvement identified and comprehensively reported against are relevant to the range of services provided, and have been developed in partnership with service users, carers, clinicians and the Member's Council. The priorities mirror a number of the areas identified by commissioners and included in CQUIN incentives.

Commissioners recognise that the report aims to meet the needs of trust boards, clinicians and staff, patients, the public and commissioners and believe that this highlights two key tensions in the presentation of the quality account report, as the report will meet the requirements of some better than others and between comprehensiveness of coverage of the range of service provided on the one hand, and length and complexity of the document on the other.

## 3.2.2 Response from Calderdale Council's Adults Health and Social Care Scrutiny Panel

Thank you for sending us your Quality Accounts for the comments of the Adults Health and Social Care Scrutiny Panel. They are a comprehensive and invaluable account of your work over the last year.

In July 2010 we had a comprehensive discussion with your Director of Corporate Development and District Service Director on mental health and learning disabilities service development. This provided an invaluable insight that provided a context for much of our discussions during the year. Many of our other discussions, although not "badged" as items about your services, considered issues of great significance to you. Examples include changes to the Fair Access to Care Scheme and the Single Commissioning Plan.

We have noted the priorities you have identified for 2011/12 and in our work programme discussions we will consider which of these are of particular interest to the Scrutiny Panel and where our involvement can add value. I hope that we will be able to contribute to next year's Quality Audit through our active involvement through the year.

Finally, I would like to thank the Trust for the attending our meetings and keeping Council members informed about developments.

### 3.2.3 Statement from Wakefield Social Care and Health Overview and Scrutiny Committee

General Overview

Throughout 2010/11 the Social Care and Health Overview and Scrutiny Committee has engaged with the Trust to review and identify quality themes and issues that members believe should be both current and future priorities. This has included specific meetings with the Trust and the provision of quarterly reports to the OSC on progress against the areas for improvement identified in the 2009/10 Quality Account. This has allowed early consideration of any potential issues that may have been of concern and has helped the OSC build up a picture over the year of the Trust's performance in relation to the Quality Account.

On the basis of this dialogue and engagement, together with the wide range of stakeholder involvement, the Committee is assured that the identified priorities are in concert with those of the public and the Trust has adequately demonstrated that they have involved patients' and the public in the production of the Quality Account.

The Committee believes the Trust has met the difficult challenge of producing an account which provides the necessary balance between technical data and performance information but considers a summary document would complement the process.

Specific comments

The OSC recognises the evidence of the quality of service delivery through accreditation processes and quality schemes. During an inquiry into dementia the committee noted that the Wakefield Memory Service has been accredited as excellent by the Memory Services National Accreditation Programme. This was supported by dementia patients and their carers and the service was highly valued by partners.

The OSC supports the view that effective care delivery can be seen in units and teams across the Trust. This was evident during the Committee review into Dementia Services when examining the effectiveness of the acute hospital liaison team. "Members acknowledged the excellent work of the acute liaison team in speeding up the discharge of patients with mental health needs from the acute hospital and in reducing the number of patients going into 24 hour care".

In terms of national service user survey evidence the OSC supports the view in relation to crisis care, which reflects other feedback from services users and their carers that crisis care is an area where they would like to see some changes made. The Committee therefore welcomes the identified priority area for improvement of better definition and more effective integration of the role of the crisis and acute services. The Committee also recognise and support the view that further work is required in 2011/12 on enabling access to people in crisis and providing adequate and appropriate support.

During the Committee's inquiry into dementia services members noted the commitment to research as a driver for improving the quality of care and patient experience and considered the research article "A Pilot Study of the Impact of NHS Transportation on Older People with Dementia". The importance of staff trained in person-centred care for people with dementia was supported by this study. The research concluded that escorts appear to improve the experience of patients with dementia during journeys to and from clinics. Through its dementia review the Committee has recommended that the local dementia strategy board conduct a review of existing local information for people with dementia and their carers and implement any identified action. We therefore welcome the priority for improvement in relation to carers in terms of improved communication.

We fully support the commitment to mutual respect between service users and teams/individuals and evidence from the Committee's dignity in care inquiry supports service user views that staff attitudes and behaviours feature as one of the most important aspects of care.

***Note: No comments were received from Kirklees Overview and Scrutiny Committee***

### 3.2.4 Comments on the Quality Accounts by South West Yorkshire Partnership Foundation Trust (The Trust) by Wakefield District LINk

Wakefield LINk welcomes the opportunity to comment on the Trust Quality Accounts, for the year 2010/2011. Although this is the second time the Trust has produced the Quality Accounts, it is the first time Wakefield LINk is commenting on these accounts. We have gone through the first year's accounts and the priorities mentioned in those accounts. The comments are produced by a Task Group, comprising of two core members and about ten participants. The Task Group has had a series of meeting among themselves and with a representative from the Trust (acting Chief Nurse). We also had a briefing from the Chairman of the LINks Task Group on Mental Health and also from the LINk's representative on the Eastern Wakefield Carer's Dialogue Group. The Chairman of this Task Group is also a member of Wakefield Metropolitan District Council's Overview and Scrutiny Committees subgroup on Quality Accounts, and therefore some of the information has come from that source. The Task Group then considered the Quality Accounts as produced by the Trust. We believe that the facts and statements made within the Accounts are correct to the best of our knowledge. We also want to be as positive as possible about the services provided by the Trust.

As to the quality of the presentation of the accounts, some of us have found the boxes in part one to be confusing and the font was too small. As to the contents of the Quality Accounts, some of us thought that they were too detailed for the general public, but we understand the reason for this (the recipients for the Quality Account include commissioners, monitor, Strategic Health Authority and maybe the Care Quality Commission). I, the Chairman, understand that the Department of Health has produced a tool kit, for service providers, as a guideline to producing the Quality Accounts. The possible solution for the above two difficulties is to produce an executive summary in a slightly larger font, in plain English, avoiding abbreviations, and to publish a glossary of every abbreviation used at the end of the accounts.

The Trust is progressing well in achieving last year's Quality Accounts plan. We welcome the priorities in this year's Quality Accounts and we hope that the Trust will soon publish the methodology and the progress of these priorities as mentioned under 2.1.2 of the Quality Accounts. However, we are disappointed to see that:

1. The trust is at level 1 of the NHS Litigation Authorities risk management standards. This maybe because of a high number of claims, a high number of reported incidences of violence and low score in Crisis Management. We hope that the Trust will make progress in obtaining level 2 status soon. ***Trust response: The level of assessment is not related to claims or incidents. The Trust took the decision to be re-assessed at level 1 as we were aware that there would most likely be a major service acquisition under Transforming Community Services which precluded our going forward with the planned level 2 assessment.***

2. We would like to know the number and grades of the staff employed by the Trust. **** Trust response: This information can be provided.***

3. We note that the Trust is making satisfactory progress in staff appraisals, but are sorry to note that staff accessing the diversity training is lower than the national average.

4. We would like to know the progress being made on the Falls Prevention Strategy, since the introduction of the latest sensor technology. **** Trust response: This information can be provided.***

5. We are sorry to note that the clinical coding error rates found by the Audit Commission in the sample of notes is 100% error rate in Primary and Secondary procedure coding which is not acceptable. ****Trust response: The trust has identified some concerns related to the audit process but acknowledges some deficiencies in clinical coding which are being addressed. The trust anticipates a more positive outcome in 2011/2012.***

### 3.2.5 Calderdale and Kirklees LINks Statement

Calderdale and Kirklees Local Involvement Networks have produced this joint response to the Quality Accounts of South West Yorkshire Partnership Foundation Trust. Receipt of the draft QA from the Trust is acknowledged. The Calderdale LINk website displayed the draft QA. Whilst recognising that the QA has a mandated format and is intended for use by knowledgeable bodies, an opportunity to engage with the lay public is missed, as the QA is not a user friendly and easily understood document. The QA joint Task Group for the two LINks has not received any formal information from the wider LINk relevant to the Trust's activities. **Members of the Task Group make the following comments based only on their own or others informal engagement.**

It is welcomed that shortcomings in the service provided are identified and reported in the QA, the improvement action, either already taken or to be implemented is not clearly evident or cross referenced. The result is that the public may not recognise that such beneficial response has happened. Examples include: Too many abbreviations in the document; Need for improved awareness of advocacy availability; Carer communications; Diversity training for staff; Access to crisis care.

As informal contacts have shown that action has been taken, it suggests that Trust information is not reaching some interested parties, thus damaging its image and that a change to the QA format could be beneficial.

Informal and limited input indicates that there remain concerns in Kirklees around the availability of beds for those in need of admission to services and that the lack of in-patient facilities in Huddersfield is unacceptable to the populace, although the need for closure of St. Lukes has been recognised. ***Trust response: The trust listens very carefully to feedback and will continue to work with our service users and carers throughout 2011/12 in respect of the service offer in Kirklees.*** The facility at Folly Hall is considered to be operating well. The Single Point of Access arrangement is welcomed but Kirklees LINk fears that the ongoing performance standard of the scheme may be at risk as it may have high operational costs. ***Trust response: being managed at cost neutral.*** The information presented on the frequency of pressure sores fails to differentiate between those arising during stay and those present on admission. (p45) Enhanced contacts between both LINks and the Trust would be welcomed.

**SWYPT QA – comments from Steering Group Member, Kirklees LINk** : This document gives a comprehensive account of how continuous quality improvement is promoted by the Trust for those who use their services. The statement (pages 5-6) from the Chief executive sets a tone of partnership with patients and carers which is felt throughout the report. There is evidence that the views of service users are integral to all aspects of service improvement. The various examples (pages 13-19) demonstrate in many ways how this is done. It is good to also see a proactive approach to reducing the stigma of mental health problems by working with schools (p 14). Perhaps there is potential for joint working with school nursing teams to further this work. There is a stated commitment to deal with complaints speedily, with examples given of learning from this (page 13) but it would be useful to know the level of complaints. ***Trust response: this information can be provided.*** The open discussion around dealing with serious incidents (page 25) is very positive as it supports a culture of openness which is key to improving patient safety. The web-based incident reporting system sounds positive – it will be interesting to see how this progresses in the future. Good to acknowledge legal claims (page 26). The methods used to identify priorities for improvement (p 32) include evidence from patients and carers via several routes – again showing patients being involved alongside staff and other sources of evidence. Local clinical audits give evidence of efforts to identify areas in need of improvement and acting on them e.g. pressure ulcers (p 45). Commitment to staff welfare is good as it has a beneficial effect on patients if staff are happy. All in all, this QA presents a positive impression of the trust – in which users and carers are an integral part of quality improvement. It is rather long – could a short summary be done next time for those who just want to get the essentials. ***Trust response: production of a summary document is under consideration.***

# PART 3 - ANNEXES

# DIRECTOR STATEMENTS

***The following statement is required by the Department of Health***

## STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY ACCOUNT

The directors are required under the Health Act 2009, National Health Service (Quality Accounts) regulations 2010 and National Health service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The department of health has issued guidance on the form and content of annual Quality accounts (which incorporate the above legal requirements).

In preparing the Quality account, directors are required to take steps to satisfy themselves that:

- The Quality Accounts present a balanced picture of the trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

3 June 2011… Date …… Chair

3 June 2011 Date …… Chief Executive

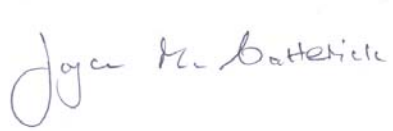
***The following statement is required by Monitor***

**2010/11 STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY REPORT**

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report. In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2010 to May 2011**;**
  - Papers relating to Quality reported to the Board over the period April 2010 to May 2011**;**
  - Feedback from the commissioners dated 24.05.2011;
  - Feedback from governors - members council quality account sub-group meetings (held 22.10.2010, 18.03.2011, 27.04.2011) and consideration at Members Council meeting dated 27.04.2011
  - Feedback from LINks (Kirklees and Calderdale dated 26.05.2011; Wakefield dated dated 24.05.2011);
  - [2]The trust's monthly and quarterly complaints reporting between April 2010 to March 2011 and the annual Hospital and Community Services Written Complaints Return (K041 (a)) submission for 2010/2011 dated 05.05.2011;
  - The national patient survey 2010;
  - The national staff survey 2010;
  - The Head of Internal Audit's annual opinion over the trust's control environment to be received 03.06.2011;
  - Care Quality Commission quality and risk profiles dated September 2010 – April 2011
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.
By order of the Board NB: sign and date in any colour ink except black

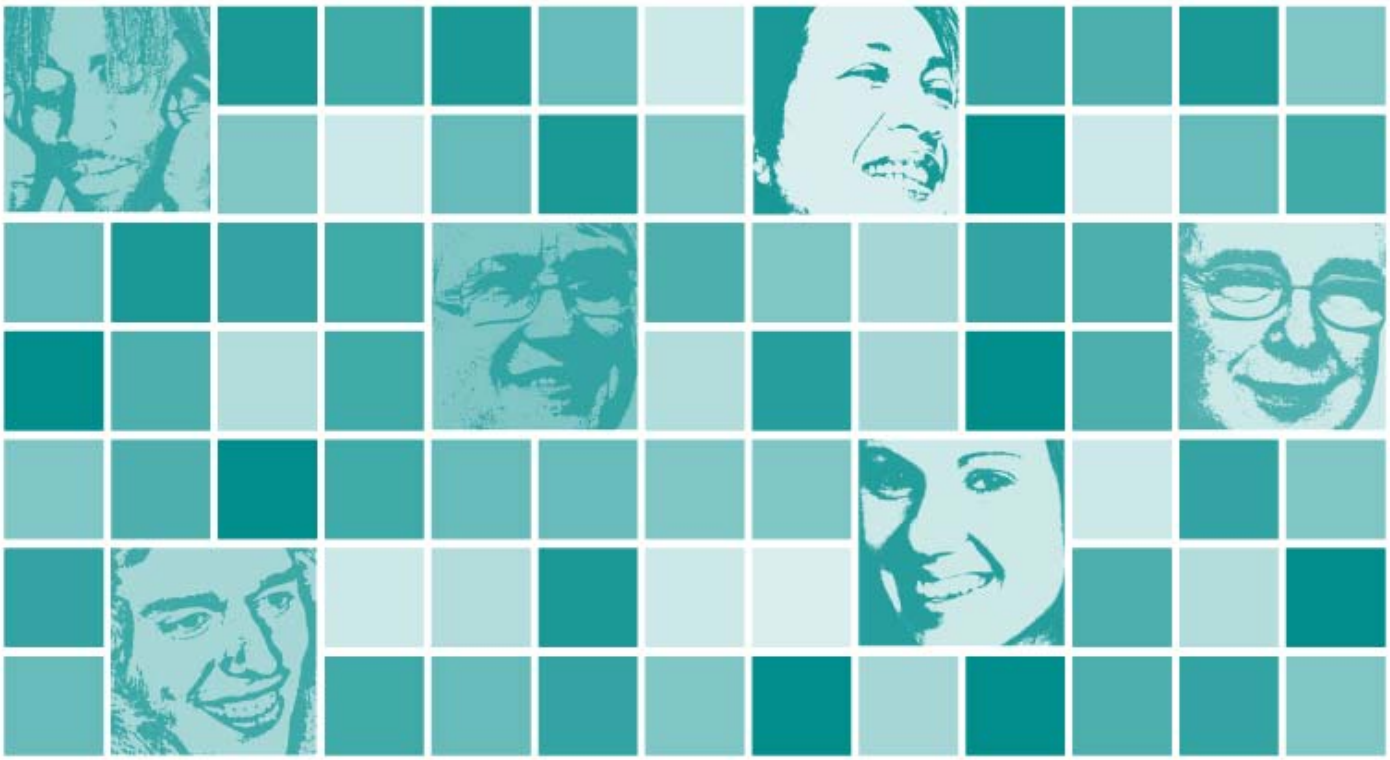


3 June 2011....Date.. ..Chair

3 June 2011....Date..... .....Chief Executive

[2] An annual report which amalgamates the information contained within the quarterly complaints reports and the K041 (a) submission will be produced in June 2011 to ensure the trust fully meets the specification for an annual complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009

# Part 4



## 4.1 Community Services Acquired Under Transforming Community Services

In 2010/11 PCTs have been working to separate their commissioning functions from their provision of services. By May 2011, as part of the 'Transforming Community Services' initiative, we will have acquired a large number of community services from NHS Barnsley as well as some services from NHS Calderdale and NHS Wakefield.

Organisations taking on the responsibility for providing community services post April 2011 are required to publish a Quality Account detailing the quality of community services in 2010-2011. Therefore in this part of the report we provide detail of the quality review completed by services transferring from NHS Calderdale and Barnsley Care Services Direct.

Services acquired from NHS Wakefield are included in the NHS Wakefield Community Services Quality Account being produced and published by NHS Wakefield.

**It should be noted that the South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) was not responsible for the services in 2010/11 and therefore the SWYPFT Trust Board will not be in a position to approve and sign off the details within Part 4 of this report until after all acquisitions are completed in May 2011**.

### 4.1.1 NHS Calderdale

**NHS Calderdale**
**Calderdale Substance Misuse Service**
**(CSMS)**
**Quality Account 2010/11**

CSMS prides itself on being very pro-active and responsive to change in order to improve the services we deliver to our client groups. This year has been no exception in that there have been many changes within the service to improve the quality of services provided. The following is a brief summary and by no means an exhaustive account of some of the improvements we have made.

We have hit 'green' for all the key PSA/ LAA targets that were set for us at a national and local level that relate to KPI's to demonstrate treatment effectiveness.

We have improved the level of take-up of Hepatitis A & B vaccinations from previous years. We are now amongst the top performing services in the country for our percentage take-up rate which means that our clients have a better chance of being protected against blood born viruses than other areas in the region. This can only improve further as we have now appointed a nurse within the Open Access Triage team who will be able to offer vaccinations at the point of entry to the service. The open access team have recently been trained to offer Hepatitis C testing at the point of entry to the service rather than having to wait for their allocated care co-ordinator to offer this at their next appointment. Pre and post test counselling for Hepatitis C is very important for our client group due to the high prevalence of Hepatitis C amongst injecting drug users. Clients are referred for further investigations for treatment if tested positive, thus the sooner someone is aware of their hepatitis status the better the outcome if referred for treatment.

A significant change this year has been the relocation of staff to one site. This has been a major upheaval but means that we can make better use of staff resources across all our service elements to improve the outcomes for our service users. The open Access triage team are now located within the main reception area to enhance the 'front face' of the service and improve the quality of harm reduction work that can be offered as clients walk through the door.

**Ambitions for 2011/12**

The launch of the new Government's Drug Strategy sees a shift in direction for drug services. We have been preparing for this strategic shift to a more 'recovery' focussed service. As early as 2009 we produced a DVD with some of our clients and workers that clearly emphasised our ambition in developing a 'recovery orientated system'. To this aim we will be working more closely with our partners and especially our service users to help increase our 'recovery capital' in Calderdale.

**NHS Calderdale**
**Calderdale Health Improvement Service**
**Quality Account 2010/11**

***Healthy Lifestyles Team Achievements***

**LAA Target:** The Healthy Weight Service achieved the Local Area Agreement Target for Adult Obesity for 2007/2010. 1457 people lost 5% bodyweight and maintained for at least 12 weeks

**Celebrating Success Improving Health Award:** The Healthy Weight Service won the Improving Health Award at the NHS Celebrating Success Awards

**Nestle:** The Healthy Lifestyles Team were commissioned by Nestle to deliver health screening nationally at eight Nestle sites. This was a development of the Workplace Health programme which has been recognised as a success in supporting Nestle to deliver its WellNes programme

**Health Champions Big Society Award**: The Altogether Better Health Champions project was awarded a Big Society Award in recognition of the great work that Health Champions have done in improving health in deprived communities. The Health Champion model has been included in the Government White Paper, Healthy Lives Healthy People as an example of good practice.

***Stop Smoking Service Achievements***

The Stop Smoking over achieved the Local Area Agreement Target for 2007-2010.

***Other Service Improvements in 2010***

To reduce weight lists for the Healthy Weight Service at one of our busiest surgeries; the Healthy Weight Advisor now contacts her clients to remind them of their appointment. This regular communication with clients has improved the attendance of the clients at the surgery. This surgery ran at an average of 95% over January and Feb 2011.

Improvements to the Stop smoking Service include provision of more rapid access through a change in service delivery to 'rolling groups' that provides more appointment slots for people to access help quickly and also enables them to get support for longer if they require it.

The Stop Smoking Pregnancy Service in Calderdale is still quite new and is being developed into a pregnancy and family service with a pilot currently running at New Road Children's centre in Sowerby Bridge where pregnant women and young parents can access the service whist their children are taking part in supervised activities The target was 15 for the year. This year 70 pregnant women have set a quit date with Lucy and 31 have quit smoking for at least 4 weeks (44%). She has also supported 8 partners/family members to quit.

**Service Improvement planned for 2011**

To develop the 2010 improvements detailed above

To continue and develop the RAG rating review of the Healthy Weight Clinics.

Pilot the Lifestyle Assessment clinics to improve the client "journey" The client would be provided with a dedicated Healthy Lifestyle Advisor to personally take them through behaviour change goals, referral(s) into appropriate Health Improvement services, and reviewing progress against personal goals.

### 4.1.2 Barnsley Care Services Direct

# NHS Barnsley
# Care Services Direct
# Quality Account
# 2010/11

**Clinical Effectiveness** **Patient Experience** **Patient Safety**

# Barnsley Care Services Direct – Quality Account

## PART 1

### 1.1 Quality highlights and challenges in 2010/11

Information presented in this part of the account relates to our overall review of quality performance which is more formally reported against in part 3.

#### 1.1.1 Clinical Effectiveness

#### 1.1.1(i) The National Institute for Health and Clinical Excellence (NICE)

NICE is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

NHS Barnsley Care Services Direct (Community) reviews practice against each piece of NICE guidance which is reported back to Commissioners and action plans are put into place. This is reported via the Patient Safety Committee and monitored by the Care Services Direct Governance Committee.

#### 1.1.1(ii) Clinical audit

Clinical audit and evaluation involves reviewing the delivery of healthcare to ensure that best practice is being carried out. Effective clinical audit and practice evaluation is critical to the development and maintenance of high quality person-centred services.

During 2010/11:

- NHS Barnsley Care Services Direct has continued to deliver a range of projects which help strengthen learning and change. For Community Services this includes the Food and Drink Audit, and the Personal and Oral Hygiene Audit, both of which involve both staff and patient participation. In Mental Health projects include:

    - Privacy and Dignity
    - Nutrition
    - Tissue viability
    - Infection Control
    - Falls
    - Self Care
    - Record Keeping
    - Personal and oral hygiene
    - Health promotion

### 1.1.1(iii) Staff

The Boorman Report (2009) showed clear links between staff health and well being and patient safety, patient experience and the effectiveness of patient care and this is fully recognised by the Trust. Indeed, the Trust was acknowledged in the Boorman Report for its excellent approach to staff support and remains fully committed to implementing report recommendations. It is only by doing this that we can reinforce model employer status, promote patient safety and strengthen service quality.

A key feature of the Trust's successful commitment to staff is its exemplar relationship with Staff Side who are fully involved in all key decisions at the 'glimmer of an idea' stage. One excellent example of such partnership working was the Trust's baseline assessment against the Investors in People (IiP) Standard. This used Staff Side as internal IiP assessors prompting wide and honest responses by staff. The results were overwhelmingly positive and suggested that IiP was easily within the grasp of the Trust should it wish to pursue a formal assessment.

The Trust has supported many celebrations of staff achievement over the years including annual Innovations Awards, Long Service Awards and awards recognising the achievement of qualifications. The Trust has obtained a highly commended award sponsored by the National Apprenticeship Service (NAS) for Large Employer of the Year, in recognition of its successful Apprenticeship programme. In reflection of this and to celebrate the outstanding achievements of Apprentices and Staff, awards have also been presented by Yorkshire and Humber Strategic Health Authority for Adult Apprentice of the Year and runner-up Champion on the year.

To evidence the Trust as a model employer, the 2010 staff survey demonstrates extremely positive results, with the Trust showing better than average in 22 of the 38 key indicators when compared to similar organisations. Of the 38 indicators, the Trust has also improved its results in 20 areas compared to last year. Of these, 12 were statistically significant improvements including:

- Quality of job design
- Work pressure felt by staff
- Trust commitment to work life balance
- Appraisal uptake
- Staff appraised resulting in a personal development plan
- Good support from immediate manager
- Receiving Health and Safety training
- Fairness and effectiveness of incident reporting procedures
- Perceptions of effective action towards violence/harassment
- Communication between senior managers and staff
- Job satisfaction (Vital Signs key measure)
- Staff recommendation as place of work or to receive treatment

In addition, the indicator for overall staff engagement was better than average compared to similar organisations, plus showed an improvement compared to the Trust's 2009 results.

In terms of maintaining and promoting patient safety, all staff are required to undertake corporate and local induction to ensure awareness of risk management policies and procedures. A mandatory training needs analysis is also in place which clearly identifies the mandatory training requirements for every member of staff. This analysis has been done in line with, and includes the areas of training identified in the NHS Litigation Authority's Risk Management Standards for PCT's. The Trust's mandatory training requirements and associated issues are routinely monitored each quarter through the Trust's Mandatory Training Review Group which

includes directors, senior managers and mandatory training providers. Attendance rates for all areas of mandatory training are also monitored and reported to the Board and senior managers each month to enable local action to be taken as appropriate.

In addition to mandatory training, the Trust is fully committed to continuing personal and professional development supporting a wide variety of training through its dedicated Centre for Learning & Development. A key success of the Centre is its partnership work with Barnsley Social Services in the establishment of a management development centre providing accredited management qualifications up to post graduate level.

Given the QIPP agenda, it is clear that maximising staff resources and reducing overheads will be essential for improving efficiencies while driving up quality. To enable this, the Trust routinely collects and reports workforce data to identify risks and costs associated with agency, bank and overtime spend, sickness absence and turnover. This approach has been extremely effective in managing hotspots and has led to consistent improvements e.g. in sickness absence during the course of the year.

Integrating equality and diversity into everything that we do has long been standard practice in the Trust. The Trust has processes to monitor and act on data in relation to equality of all employees including recruitment, promotion, development, bullying and harassment. There is also a Trust wide Equality and Diversity Committee to ensure consistent implementation of Single Equality Scheme.

The Trust works with local organisations to tackle inequalities and provide supportive programmes of training and work experience placements under schemes such as Work Step/Prep, Sure Trust and BTCV. It creates suitable employment and training opportunities to support people from disadvantaged backgrounds, who have a disability or no qualifications to overcome barriers and achieve a job or training goal. It has been successful in offering employment opportunities to individuals who have accessed these schemes.

The Therapeutic Employment project within Mental Health is a flagship project, offering service users an alternate pathway to gain experience and work based learning, whilst supporting their journey to recovery, independence and employment.

During 2010 the NHS Barnsley Staff Support Service offered free health checks to all NHS Barnsley employees as part of its 'Live for Life' initiative, which aims to promote and encourage lifestyle changes to employees. Clearly this contributed to the Trust's aim to improve health and wellbeing, reduce sickness and therefore contribute to service quality and effectiveness.

### 1.1.1(iv) Effective financial controls

NHS Barnsley Care Services Direct (Community) has robust systems and financial controls in place which can be demonstrated by the continuous delivery of all financial targets over the last 3 years. These targets include a planned surplus each year and also national efficiency targets.

In 2010/11 NHS Barnsley Care Services Direct (Community) has a planned surplus of £506k as well as a significant cost improvement programme £5m to deliver. The governance arrangements and performance management framework allow us to closely monitor performance and ensure both these targets are achieved.

A result of having effective financial controls in place for financial management and governance means we can demonstrate value for money. This can be evidenced by our track record where we have consistently achieved an overall level 3 in the 'Use of Resources' assessment for the last 3 years.

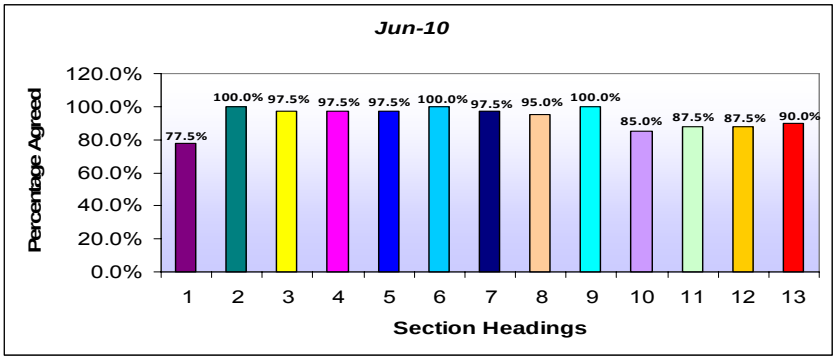
### 1.1.2 Patient Experience

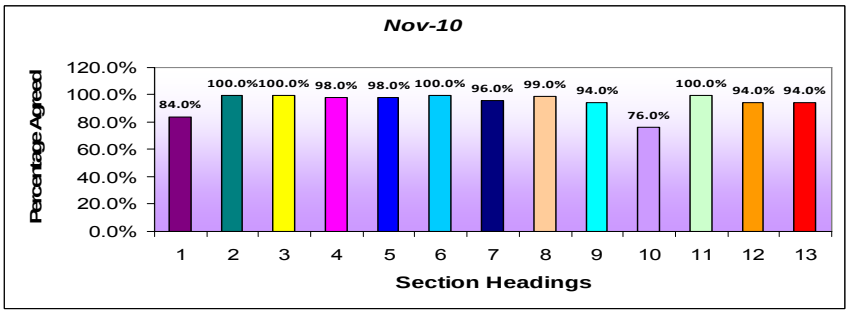
### 1.1.2(i) Patient Satisfaction Surveys

To enable us to take appropriate actions to improve patient experience all services in the organisation conduct Patient Satisfaction Surveys. Information regarding the bi-yearly surveys conducted by Mount Vernon Hospital (our largest facility for in-patient/community services) is shown below.

**Table 1 Patient Experience of In-patient Services at Mount Vernon Hospital**

| | Survey questions | Jun-10 | Nov-10 |
|---|---|---|---|
| 1 | Overall would rate their experience excellent or very good | 77.5% | 84.0% |
| 2 | Given enough privacy when discussing their condition and treatment | 100.0% | 100.0% |
| 3 | Had someone to talk to about their worries and fears | 97.5% | 100.0% |
| 4 | Were involved in decisions made about their care and treatment | 97.5% | 98.0% |
| 5 | Agreed that meals provided were of good standard | 97.5% | 98.0% |
| 6 | Agreed that the environment looked clean and tidy | 100.0% | 100.0% |
| 7 | Agreed ward staff had asked for consent before giving treatment or care | 97.5% | 96.0% |
| 8 | Were treated with respect and compassion | 95.0% | 99.0% |
| 9 | Felt privacy and dignity was maintained at all times | 100.0% | 94.0% |
| 10 | Had access to a single sex lounge | 85.0% | 76.0% |
| 11 | Did not pass through opposite sex sleeping areas as a patient of the opposite sex | 87.5% | 100.0% |
| 12 | Never used the same bathroom or shower areas as a patient of the opposite sex | 87.5% | 94.0% |
| 13 | Did not share a sleeping area with a patient of the opposite sex | 90.0% | 94.0% |




In relation to patient satisfaction mental health inpatient services obtain 100% compliance with same sex accommodation. The unit compromises of male and female inpatient areas ensuring privacy and dignity at all times.

### 1.1.2(ii) Eliminating Mixed Sex Accommodation

The Department of Health has had a commitment to the Elimination of Mixed Sex Accommodation for several years. The commitment has been reiterated in the Operating Framework for 2011/12 and sanctions in the form of fines for breaches of the standard have been introduced.

In addition, Trusts will be required to declare any breaches of this guidance and there will be a league table published to inform the general public.

NHS Barnsley Care Services Direct has been committed to this agenda since 2009 and has made substantial changes to accommodation to assure high quality provision of facilities that meet the privacy and dignity of patients.

Across all the sites there has been a substantial financial commitment and a responsive facilities department has enabled works to be priorities that meet this agenda.

This has resulted in the achievement of single sex accommodation across the Keresforth and Mount Vernon Hospital sites, and no breaches of the standard have been reported. A newly refurbished ward 6 on the Kendray site, redesigned to assure the single sex agenda, will open in April 2011.

NHS Barnsley Care Services Direct has achieved the standards set out by the Eliminating Mixed Sex agenda and has processes in place to ensure adherence to the same.

### 1.1.3 Patient Safety

### 1.1.3(i) NHS Litigation Authority (NHSLA) - Risk Management Standards

The NHS Litigation Authority (NHSLA) works to improve risk management standards in the NHS. The standards involve minimising any threats to safe effective services and care. It also requires the management of any remaining risks in a sensible and carefully considered way.

There are a set of risk management standards for each type of healthcare organisation. The Acute Trusts, Primary Care Trusts and Independent Sector Providers of NHS Care standards provide NHS Barnsley Care Services Direct with a structured framework to make sure we manage risk as well as we are able. This then helps us to improve the quality of the care and services we provide.

Organisations are regularly assessed against the NHSLA risk management standards, which include not only how the organisation is run and how it manages its risks which include clinical, and health and safety risks, but how staff are recruited and trained.

In March 2010 NHS Barnsley Care Services Direct undertook a level 1 assessment against the above standards and successfully achieved a 100% compliance rate with all 50 criteria.

### 1.1.3(ii) Information Governance

NHS Barnsley Care Services Direct needs high quality, accurate and reliable information to help us provide excellent care, as well as plan future services, monitor performance and manage resources. So, it is very important that we make sure information is efficiently managed and stored. We also need to protect the information we have against theft, malicious damage or accidental damage. This is all known as information governance.

The NHS Operating Framework for 2009/10 requires organisations to achieve level 2 performance against all key requirements identified in the information governance toolkit – this toolkit helps us check that we have policies and procedures in place to look after information. The toolkit relates to 25 standards that form the Information Governance Statement of Compliance (IGSoC). NHS Barnsley Care Services Direct, like all NHS organisations, must sign the IGSoC to confirm that we are meeting all the key requirements, and we must demonstrate we have strong, comprehensive plans in place to improve where we need to, against any other requirements. NHS Barnsley Care Services Direct ensures that any information governance incidents are reviewed with training and support provided for staff to ensure ongoing vigilance.

Data quality is also very important to NHS Barnsley Care Services Direct. This is about making sure that clinical information is accurately and consistently recorded. By doing this we cannot only help improve patient care, but also reduce clinical risk and show how we are meeting national standards.

### 1.1.3(iii) Safeguarding

Vulnerable people deserve the best protection we can give them. We are fully committed to ensuring we do everything we can to ensure this always happens.

#### Children and Young People

The Children Act (2004) states that safeguarding children is everyone's responsibility. Section 11 of the Children Act places a duty on key persons and bodies to make arrangements to ensure that, in discharging their functions, they have regard of the need to safeguard and promote the welfare of children. NHS Barnsley Care Services Direct has in place:

- A board level executive director lead for safeguarding, the board reviews safeguarding across the organisation at least once per year and has robust audit programmes to assure it that safeguarding systems and processes are working.
- A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children.
- Service developments take account of the need to safeguard children and are informed, where appropriate, by the views of children and families.
- All staff receive safeguarding children training as per the training strategy, this is monitored monthly and reported to the board quarterly.
- Safe recruitment procedures are in place and have been audited.
- There are many examples of effective interagency working i.e. the trust contributes to audits undertaken on behalf of the safeguarding board bi-annually. NHS Barnsley Care Services Direct recognises the importance of interagency working and are continually striving to improve this.

In February 2009 the Healthcare Commission (HCC) asked all organisations to complete a Safeguarding Children review. Feedback was expected from this in April 2009, however, because the HCC was superseded by the Care Quality Commission in April 2009, the findings from the review were published in 2009, in conjunction with a letter from David Nicholson, NHS Chief Executive (Gateway reference number 12228). Many of the recommendations were already in place as described above, however the organisation has worked very hard and continue to do so to ensure compliance.

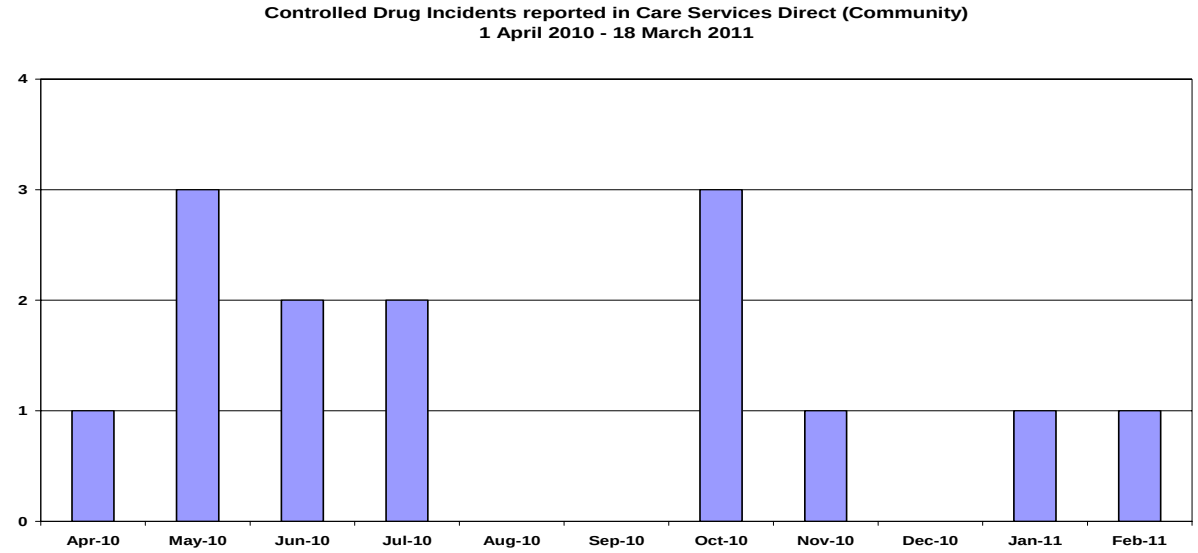
#### Vulnerable Adults

In 2010/11 work has been ongoing within NHS Barnsley Care Services Direct to improve the provision of services for Safeguarding Adults and to streamline the current systems available, helping staff to know what to do and each persons individual responsibilities. Training has been a primary focus ensuring that there are sufficient numbers of staff in each area with appropriate knowledge of Safeguarding Adults. Training has been devised to fit both general and advanced levels of knowledge and this is being delivered on a regular basis within the training department.

The process for identifying Safeguarding issues has been clarified through a process map, staff have been reminded of the process and gaps have been identified where the current system has problems. Safeguarding Managers have been identified and the list has been reviewed to ensure that identified Safeguarding Managers are appropriately trained and can be released to carry out investigations when required.

### 1.1.3(iv) Controlled drugs

The information in the chart below indicates the Controlled Drugs Incidents reported within NHS Barnsley Care Service Direct from 1 April 2010 to 18 March 2011.




There is a statutory requirement for all organisations registered with CQC to report Controlled Drugs incidents to their Accountable Officer for Controlled Drugs. An annual audit into the storage and handling of Controlled Drugs is also undertaken by NHS Barnsley Care Services Direct and this has identified a need for additional training of nursing and medical staff. The new Pharmacy Contract and the subsequent increased capacity of the Pharmacy Team mean that additional training and vigilance with regard to Controlled Drugs will become possible.

### 1.1.3(v) Learning from Serious Incidents (SI)

Many people use our services over a year and receive high standards of care. However, occasionally incidents do occur, and it is important they are reported and managed effectively. The Trust has very strict processes for the reporting and management of all incidents to ensure that they are always thoroughly investigated, analysed and monitored, so that NHS Barnsley Care Services Direct can learn any lesson and try to prevent recurrence in the future where possible. NHS Barnsley Care Services Direct will always learn as much as possible from both internal and external incident reviews and is committed to being open with patients, service users and families if things do not go as well as expected. In the last year NHS Barnsley Care Services Direct has not reported a 'Never Event'.

Never Events are patient safety incidents that are preventable because:

- There is guidance that explains what the care or treatment should be.
- There is guidance to explain how risks and harm can be prevented.
- There has been adequate notice and support to put systems in place to prevent them from happening.

We will continue to not only try and prevent all types of incident from occurring, but when they do we will learn from them to help further improve the quality of our services.

# PART 2

## 2.1 Priorities for improvement

### 2.1.1 Identification of Priorities

The priorities for 2011/12 build on what has already been achieved from a quality perspective, reflecting the commitment of clinical staff in responding to the national and local agenda for quality improvement. Clinical effectiveness, patient safety and importantly patient experience are already embedded significantly in the culture of Barnsley Health and Social Care economy. Further development will take place within the culture of partnership with SWYPFT and learning from their experience. To help us to identify meaningful quality priorities for 2011/12 account has been taken of the following:

- Commissioner CQUIN targets
- Patient feedback and surveys
- Incident Reporting
- QIPP Initiatives
- Services redesign
- Professional Forum (Chair Director of Nursing)
- High Impact Professional Group (Chair Assistant Director of Nursing)
- Quality Account Forum (newly formed)

It should be noted that patient involvement will be developed in future quality accounts.

**Table 2: Priorities for improvement in 2011/12**

| Priority | Improvement initiative areas |
|---|---|
| Medicines Management | Focusing on improved patient safety (medicines reconciliation at admission) and patient experience (more information about medicines at discharge). |
| (COMMUNITY)<br>Personalised Care | Initial focus to be on patients approaching End of Life i.e. those perceived to be in the last 6 – 12 months of life.<br>Use of personalised and shared advance care plans (preferred priorities for care document and last days of life care pathway).<br>Lessons learned to be applied to wider roll out of personalised care planning for all patients with Long Term Conditions. |
| (COMMUNITY)<br>Zero Tolerance of Avoidable Healthcare Associated Infection - C Difficile | Reduction in Clostridium Difficile. |
| (MENTAL HEALTH)<br>AIMS Accreditation | The AIMS accreditation process incorporates elements that research has demonstrated to be effective in bringing about quality improvement. It gives encouragement to identify and prioritise problems and set achievable targets for change. Membership of AIMS can help wards meet the Care Quality Commission's Standards for Better Health and to conform to NICE guidelines. |
| (MENTAL HEALTH)<br>Refurbishment of Ward 6 and its integration into the acute care pathway | Ward 6 provides acute inpatient care to older adults with mental health problems. The refurbishment is in line with CQC standards and recommendations concerning single sex accommodation. Last year the acute wards for working age adults were involved with the Rapid Improvement Programme in developing a pathway of care.<br>We are in the process of implementing this program to Ward 6 |

See table 3 for the reasons these were chosen as priorities.

**Table 3: Our quality priorities for improvement in 2011/12 and why we decided on them**

| 1. Medicines Management | Clinical Effectiveness. Patient Experience. Patient Safety. |
|---|---|

In May 2011 NHS Barnsley Care Services Direct (Community) is moving to a new method of supply of medicines, meaning that medicines will routinely be dispensed and supplied by Lloyd's pharmacy. This will free up the current pharmacy team to be more involved on the wards, particularly in medicines reconciliation at admission (NICE 2008), which means that the medicines people are taking when they get in to hospital will more accurately reflect what they were taking at home, therefore making their medicines safer and more effective. Pharmacy staff will also be involved in helping people with taking their medication at discharge. This will improve adherence with medication regimes and possibly reduce readmission to hospital. This will also improve the patient experience. Pharmacists will also be able to be involved with Multi Disciplinary Team (MDT) meetings more regularly and therefore they will be able to influence the choice of medication, increasing safety and patient experience. The team will also be able to undertake training with ward staff, increasing safety and effectiveness of medicines.

| 2. Personalised Care | Clinical Effectiveness. Patient Experience. Patient Safety . |
|---|---|

Within the Barnsley Health and Social Care Community there is strategic commitment to ensuring that our service users are fully involved in the planning and delivery of their care. The People in Control (PiC) programme is a 3–5 year programme which will provide Barnsley residents with the ability to identify and obtain their own health and wellbeing needs with services that will sympathetically consider each person's need from their viewpoint. From a national perspective personalised care is a critical component of a number of initiatives:

- End of Life Care Quality Markers (DH 2009) Mechanisms in place to assess and document the needs of those approaching the end of life and to discuss, record and (where appropriate), communicate the wishes and preferences of those approaching the end of life (advance care planning).
- Care Quality Commission Essential Standards of Quality and Safety – Outcome 1: Respecting and involving people who use services.
- High Quality Care for All: The NHS Next Stage Review Final Report (originally made in Our Health Our Care Our Say White Paper) to offer everyone with a Long Term Condition (LTC) a personalised care plan.
- NHS Operating Framework 2010/11 and in NHS 2010-2015 from Good to Great.

Barnsley's end of life care strategy and the national end of life care strategy clearly highlight that the provision of end of life care (defined as last year(s) of life) should be "everyone's business" i.e. it is care provided by all staff in all settings to people dying from all conditions, and that individualised choice is essential if high quality end of life care which affords dignity and respect is to be provided.

To develop care in Barnsley, where these principles are central, an end of life care team was established to provide support and education to generalist staff. A whole system approach was taken and although employed by NHS Barnsley Care Services Direct (Community) the remit of the team was to work with staff of all disciplines across the district including acute and social care. A key component to this work involves the use of 2 key nationally recommended tools; the Preferred Priorities of Care document and Last Days of Life Care Pathway (local equivalent of Liverpool care pathway for the dying patient).

| 3. Zero Tolerance of Avoidable Healthcare Associated Infection - C Difficile | Clinical Effectiveness. Patient Experience. Patient Safety. |
|---|---|

Since 2004 the reporting of C Difficile infection has been mandatory. All NHS Trusts are required to test diarrhoeal stool samples from patients 2 years of age or older and report all positive results to the Health Protection Unit. Operating Framework (2008/09), subsequently 2009/10 and 2010/11 - Service quality - NHS organisations should aim for zero tolerance on all Healthcare Acquired Infection (HCAI) and have plans in place for best practice. It is a significant cause of distress to patients, their families and NHS staff, that occasionally the action we take to help people sometimes results in unintended harm. It is also increasingly a key issue for public confidence in the NHS. No healthcare system can ever be entirely risk free, but we must do more to reduce the rate of HCAIs. Organisations took particular action in 2008/09 to ensure progress national targets:

- *Clostridium difficile*: differential Strategic Health Authority (SHA) envelopes to deliver a 30% reduction nationally by 2011, compared to the 2007/08 baseline figure.
- SHA yearly trajectory figures for C Difficile infections. There are SHA trajectory targets for the Primary Care Organisation (PCO) and in addition there have been locally agreed target trajectories put in place.
- The Health and Social Care Act 2008 established the Care Quality Commission in place of the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission, to register, review, investigate and support improvements in the care provided to patients. NHS Barnsley Care Services Direct registered compliance with the requirements in relation to HCAI for 2010/11.

| 4. AIMs Accreditation | Clinical Effectiveness. Patient Experience. Patient Safety. |
|---|---|

Member services are supported through a 12-month review process that incorporates:

**OBJECTIVES**

The purpose of AIMS is to improve the care provided by acute inpatient mental health wads in the United Kingdom and Ireland. It will achieve this by:

- Accrediting acute inpatient mental health wards
- Creating a national network to support staff through;
  - a database of standards for acute inpatient care;
  - the AIMS peer-review process;
  - an email discussion group
- Maintaining a database of standards for acute inpatient care.
- self-review, including carer, patient and staff questionnaires;
- a one day peer-review visit;
- a recommendation of accreditation status by the AIMS Accreditation Advisory Committee;
- Ratification of accreditation status by the Royal College of Psychiatrists' Education, Training and Standards Committee.

Accreditation is valid for up to four years, subject to satisfactory completion of an annual self-review.

| 5. Refurbishment of Ward 6 and its integration into the acute care pathway | Clinical Effectiveness. Patient Experience. Patient Safety |
|---|---|

The rapid improvement program discussion group highlighted “timely discharges” in acute adult inpatient services as the main focus for quality improvement in patient care. The group looked at the “patient journey” throughout inpatient services using case studies and discussion groups (involving staff from all disciplines of the MDT including care coordinators from community mental health teams). This was to identify the process of admission or the “care pathway.”

Alongside the work of the rapid improvement program, the intensive home based treatment team identified the positive impact of improved communication and seamless working with inpatient services on both reducing the duration of admission and improving the quality of patient care/ patient journey by clearly identifying the reasons and objectives for the admission. This resulted in the permanent allocation of an IHBTT link worker to work within the MDT.

As part of the development of this role and through discussion within the rapid improvement program group, the importance of a “72 hour MDT review” led to the development of a 72 hour review planner in which a 72 hour review would be arranged inviting all relevant professionals including community mental health representatives along with the service user and relevant carers. The purpose was to highlight the reasons for admission (supported by the admission care plan completed by IHBTT), and what plan of care is needed to ensure a timely discharge can be facilitated. Whilst the positive impact of the 72 hour review process has been clear to see, the earlier analysis through case studies and discussions with staff working across mental health services highlighted that there were many other processes involved throughout a service users admission that influence the ability to ensure timely discharges. These were not only critical in terms of whether they actually occurred (such as the 72 hour review) and the timing of these processes but also the quality of these processes for example clearly defined risk statements and consideration of all options of care including leave. Each of these processes can be measured and the rapid improvement program group plan to conduct a 6 month audit of clinical records from inpatient admissions (pre-introduction of the 72 hour review planner) to look at these processes. There will also be the introduction of a care pathway document (at least covering the first 72 hours of admission) onto inpatient wards (including PICU).

The findings of the audit will be measured against outcomes from a second audit of clinical records from admissions occurring later this year to consider the impact of the 72 hour review planner and the introduction of the care pathway document. The initial audit, once analysed will also highlight current practice around the identified processes involved in the patient journey and allow for interventions to improve the quality of practice and the care delivered.

### 2.1.2 How progress against identified priorities will be monitored and measured

- The Trust Board will steer the Public Engagement and Patient Experience Strategic Group.
- The priorities will be reviewed and debated through the Public Engagement and Patient Experience Strategic Group, cascading to local implementation groups.
- Identified indicators relating to each priority area, will be monitored throughout the year.
- The priorities will underpin specific reviews throughout 2011/12 under the three quality headings of 'clinical effectiveness', 'patient experience', and 'patient safety'.
- Performance against local Commissioning for Quality and Innovation (CQUIN) targets will be measured.
- The priorities will be reflected in the audit and evaluation processes i.e. questions related to priorities will be included in local service user surveys.

### 2.1.3 How progress to achieve the priorities will be reported

- Identified indicators will be reported within Trust Board reporting schedules and processes.
- Throughout 2011/12 specific review reports will be given to the Trust Board under the three quality headings of 'clinical effectiveness', 'patient experience', and 'patient safety'.
- The Trust's prioritised audit and evaluation programme will be monitored throughout the year. This will enable issues relating to the priorities to be identified and reported.
- Stakeholder engagement processes throughout 2011/12 will be reported to the Trust Board.
- The local CQUIN targets will be monitored, reviewed and reported. This will be within contractual monitoring and quality review processes with commissioners.

## 2.2 Review of Services

### 2.2.1 Service Review

During 2010/11 NHS Barnsley Care Services Direct provided and/or sub-contracted 33 NHS Services. The Trust has reviewed all the data available to them on the quality of care in 33 of these NHS services. The income generated by the NHS services reviewed in 2010/11 represents 100% of the total income generated from the provision of NHS services by NHS Barnsley Care Services Direct for 2010/11.

### 2.2.2 Participation in clinical audits

Clinical audit and evaluation involves reviewing the delivery of healthcare to ensure that best practice is being carried out. Effective clinical audit and practice evaluation is critical to the development and maintenance of high quality person-centred services.

### National audits

During 2010/11, six national clinical audits covered NHS services that NHS Barnsley Care Services Direct (Community) provides and six national clinical audits covered NHS services that NHS Barnsley Care Services Direct (Mental Health) provides. During that period NHS Barnsley Care Services Direct (Community) participated in two (33%) national clinical audits which it was eligible to participate in. The national clinical audits that NHS Barnsley Care Services Direct (Community) was eligible to participate in during 2010/11 are shown in table 4. NHS Barnsley Care Services Direct (Mental Health) also participated in two (33%) national clinical audits which it was eligible to participate in. The national clinical audits that NHS Barnsley Care Services Direct (Mental Health) was eligible to participate in during 2010/11 are shown in table 6.

**Table 4: National clinical audits (Community)**

| National clinical audits that NHS Barnsley Care Services Direct (Community) was eligible to participate in during 2010/11 | Actual Participation |
|---|---|
| Renal Services (patient transport) Audit | |
| Renal Services (vascular access) Audit | |
| Inflammatory Bowel Disease Audit | |
| The Sentinel Stroke Audit | |
| Falls and Bone Health Audit | ✓ |
| Continence, Bladder and Bowel Care Audit | ✓ |

**Table 5: National clinical audits data collection 2010/11 (Community)**

| Audit | Data collection period | Number of cases submitted |
|---|---|---|
| Falls and Bone Health Audit | December 2010 | No minimum sample identified |
| Continence, Bladder and Bowel Care Audit | November 2009 – January 2010 | Numbers variable for each month of submission |

**Table 6: National clinical audits (Mental Health)**

| National clinical audits that NHS Barnsley Care Services Direct was eligible to participate in during 2010/11 | Actual Participation |
|---|---|
| Privacy and Dignity | |
| Nutrition | ✓ |
| Tissue viability | |
| Infection Control | ✓ |
| Falls | |
| Self Care | |
| Record Keeping | ✓ |
| Personal and oral hygiene | |
| Health promotion | |

**Table 7: National clinical audits – outcomes / actions**

| Audit | Audit Outcomes / Actions |
|---|---|
| Falls and Bone Health Audit | Work on this audit is ongoing, the final report is due May 2011.<br>An older people service local audit was undertaken in regard to use of falls risk assessment tool (FRAT) for new admissions. In-patient and community areas were audited by a questionnaire to clinical staff. |
| Continence, Bladder and Bowel Care Audit | The national audit provides the largest, most detailed evaluation of continence care in Europe. This latest round demonstrates that, although the amount of authoritative guidance is increasing, the quality of continence care remains variable and in some respects remains poor. The Continence Nurse Specialist will lead on action points arising from this audit. |

## Local audits

Clinical audit and evaluation involves reviewing the delivery of healthcare to ensure that best practice is being carried out. Effective clinical audit and practice evaluation is critical to the development and maintenance of high quality person-centred services. The Trust undertakes a significant programme of clinical audit. Clinical audit is intrinsic to practice and forms a baseline for improvements in practice and service delivery and the lessons learned are fed back through local governance arrangements and best practice forums such as medicines management and professional forums. In Mental Health the reports of 31 local clinical audits were reviewed by the provider in 2010 and Care Services Direct has identified actions for each unit which are monitored through local governance groups. Specific mental health audits include the suicide prevention audit, aspergers audit, recovery model audit and various medication audits. Prioritised Trust wide and local clinical audits are included in this section of the quality account. These audits are reported to and received by the Care Services Direct Governance Committee and the Commissioner Governance Committee. NHS Barnsley Care Services Direct intends to take the following actions to improve the quality of healthcare provided (see tables 9 and 10). As part of the prioritised audit programme in 2011/12 the Trust will include any required audit to support local CQUIN reporting requirements.

**Table 8: Local clinical audits – outcomes / actions (Community)**

| Local audit, audit period, and sample numbers | Audit Outcomes / Actions |
|---|---|
| Re-audit of Safety of Medicines in Locality Centres October 2009 – April 2010<br>23 staff observed across 2 Locality Centres - Highfield Grange and Greenside House. | This observation audit demonstrated that all locality centre staff who administer medications, followed correct procedures regarding the safe administration of medication. All locality centre staff who administer medications will be observed and reassessed on an annual basis. |
| Audit of Wound Management/Wound Assessment Chart (Pressure Ulcers/ Pressure Sores) November 2009 – April 2010<br>Questionnaires completed by 39 nursing staff covering 12 in-patient areas. (Including hospital settings and care homes). | Actions implemented include:<br>• Wound Assessment Charts in place for all patients with wounds.<br>• To ensure pressure ulcer risk assessments are reviewed and recorded weekly.<br>• Improvements to the reporting procedure. |
| Audit on Venous Thromboembolism Prophylaxis August 2010 – December 2010<br>50 patient notes audited within Rehabilitation Wards at Mount Vernon Hospital. | Actions implemented include: Assessment of patients on admission for DVT prophylaxis; Production of a patient information leaflet.<br>Re–audit (to include contra indication of clexane treatment) will take place in approximately 12 months time. |
| Musculoskeletal (MSK) Injection Audit<br>March 2010 – February 2011<br>Random selection of 100 patient notes held at the MSK service, Keresforth. | Actions implemented include: Providing patients with information leaflets detailing the risks and benefits of MSK injection; Ensure all clinicians gain written consent from patients before the MSK injection is administered, and that the type of drug and dosage is recorded in patient notes. |
| Trust wide Record Keeping Audit<br>July 2010 – March 2011<br>Random selection of 535 patient case notes covering 107 Trust wide services. | This audit was conducted using the organisations Record Keeping Standards which are based on the Essence of Care Record Keeping Benchmarks. There are 11 standards which include; Care Planning, Risk Assessments, and Consent to Information Sharing. All services have produced individual reports and action plans to improve the standard of record keeping. This is an annual audit and the next re-audit will take place in July 2011. |
| Trust wide Essence of Care Food and Drink Audit. July 2010 – March 2011. 130 members of staff, covering 12 in-patient areas, completed staff questionnaires. 55 in-patients, over 12 in-patient areas, verbally interviewed by the Environmental Manager who completed the patient questionnaire on their behalf. | The Nutrition and Oral Hygiene Sub Group will oversee:<br>• The review of the Framework for Nutrition.<br>• The production of patient information leaflets regarding 'healthy eating' and 'gaining weight'.<br>• The further development of Nutrition Training.<br>• The development of informative guidelines regarding the type of food and drink that can be brought in for in-patients during their stay in hospital. |
| Hand Washing Audit – Mount Vernon Hospital | Actions implemented include: |

| | |
|---|---|
| (Infection Control) April 2010 – September 2010 The Infection Control Team carried out 10 observations of clinical staff each week within Mount Vernon Hospital over a 6 month period. In total 630 observations were made. | • Audit results cascaded to all staff via sisters' meetings and ward meetings to ensure high standards of hand hygiene are maintained.<br>• To ensure mandatory hand hygiene training and champions training are attended by all staff.<br>• To ensure stocks of hand gel are maintained on wards. |
| Hand Washing Audit – Kendray Hospital (Infection Control) July 2010 – September 2010 The Infection Control Team carried out 10 observations of clinical staff each week within Kendray Hospital over a 3 month period. In total 307 observations were made. | Actions implemented include:<br>• Audit results cascaded to all staff via sisters' meetings and ward meetings to ensure high standards of hand hygiene are maintained.<br>• To ensure mandatory hand hygiene training and champions training are attended by all staff.<br>• To ensure stocks of hand gel are maintained on wards. |
| Enteral Feed, Catheter Care and Catheter Insertion Audit (Infection Control) April 2010 – September 2010. The following observations were carried out by the Infection Control Team within Mount Vernon Hospital over a 6 month period:<br>o 17 – Enteral Feed<br>o 27 – Catheter Care<br>o 25 – Catheter Insertion | This observation audit demonstrated that all wards at Mount Vernon Hospital achieved 100% compliance.<br>Data will continue to be collected on a regular basis to ensure high standards are maintained. |

**Table 9: Local clinical audits – outcomes / actions (Mental Health)**

| Local audit, audit period, and sample numbers | Audit Outcomes / Actions |
|---|---|
| Re-audit of Safety of Medicines Management in Acute Mental Health Services | Inpatient Clinical Ward areas are subject to staff being uptodate and compliant with medications with respect programme identifying correct procedures regarding the safe administration of medication |
| Audit of Wound Management/Wound Assessment Chart (Pressure Ulcers/Pressure Sores) November 2009 – April 2010 After liaison with Tissue Viability Link professionals were identified for inpatient areas. Mental Health Services were able to access specialist advice and support with wound care protocols | Actions implemented include:<br>• Wound Assessment Charts in place for all patients with wounds.<br>• To ensure pressure ulcer risk assessments are reviewed and recorded weekly.<br>• Improvements to the reporting procedure. |
| Trust wide Record Keeping Audit<br>July 2010 – March 2011<br><br>Random selection of patient case notes covering Acute Inpatient Care Trust wide services. | This audit was conducted using the organisations Record Keeping Standards which are based on the Essence of Care Record Keeping Benchmark. There are 11 standards which include; Care Planning, Risk Assessments, and Consent to Information Sharing. All services have produced individual reports and action plans to improve the standard of record keeping. This is an annual audit and the next re-audit will take place in July 2011. |
| Trust wide Essence of Care Food and Drink Audit July 2010 – March 2011<br>Ongoing audits are planned in relation to nutritional risk screening and nutritional benchmarks. Link Nurses from inpatient ward areas have been identified to promote diet and nutrition. | The Nutrition and Oral Hygiene Sub Group will oversee:<br>• The review of the Framework for Nutrition.<br>• The production of patient information leaflets regarding 'healthy eating' and 'gaining weight'.<br>• The further development of Nutrition Training.<br>• The development of informative guidelines regarding the type of food and drink that can be brought in for in-patients during their stay in hospital. |
| Hand Washing Audit – Kendray Hospital (Infection Control) July 2010 – September 2010 The Infection Control Team carried out 10 observations of clinical staff each week within Kendray Hospital over a 3 month period. In total 307 observations were made. | Actions implemented include:<br>• Audit results cascaded to all staff via sisters' meetings and ward meetings to ensure high standards of hand hygiene are maintained.<br>• To ensure mandatory hand hygiene training and champions training are attended by all staff.<br>• To ensure stocks of hand gel are maintained on wards. |

The following were new local audits in 2010/2011 – reports were not completed at the time this quality account was produced.

**Table 10: Local clinical audits – reports not yet completed**

| Local audit | Current status | Report completion |
|---|---|---|
| Audit of NICE Clinical Guideline No 32 – Nutritional Support in Adults | Report writing/action planning. | Report aimed to be completed by the end of May 2011. |
| Trust wide – Essence of Care Personal and Oral Hygiene Audit | Data collection – staff questionnaires were distributed in March 2011. It is aimed to complete in-patient questionnaires in April 2011. | The Nutrition and Oral Hygiene Sub Group aim to complete the report by the end of October 2011. The sub group will then implement and monitor any action points identified. |
| Controlled Drugs Audit | Report writing/action planning | Draft report to be presented to the Medicines Management meeting in May 2011. |
| Medicines Management Audit | Data entry/data analysis | Draft report to be presented to the Lead Pharmacist by the end of March 2011. |
| Audit of Blood Transfusion Procedure | Action planning | Report aimed to be completed by the end of April 2011. |

### 2.2.3 Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by NHS Barnsley Care Services Direct (Community) in April 2010 to March 2011 that were recruited during that period to participate in research approved by a research ethics committee was 880.

The number of patients receiving NHS services provided or sub-contracted by NHS Barnsley Care Services Direct (Mental Health) in 2009/10 to March that were recruited during that period to participate in research approved by a research ethics committee was nil. Although there is no completed research for the period 2009/10, there is a current ongoing research project with regard to the efficacy of Cognitive Behavioural therapy within an inpatient facility.

In 2010/11 the Trust was involved in 21 clinical research studies, seven of which were NIHR Portfolio adopted studies.

### 2.2.4 Goals agreed with commissioners

A proportion of Care Services Direct income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between NHS Barnsley Care Services Direct and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Further details of the agreed goals for Care Services Direct for 2010/11 and for the following 12 month period are available at http://www.institute.nhs.uk/commissioning/pct_portal/2010%1011_cquin_schemes_in yorkshire_%26_the_humber.html#2 – select Barnsley Care Services Direct. Details are also available via Business Performance Manager or the Contracts Manager.

For 2010/11 the CQUIN scheme was made up of a regional set of indicators and a locally developed set of indicators concentrating on local priority areas.

### 2.2.4(i) Commissioning for Quality and Innovation (CQUIN)

The CQUIN payment framework aims to support the cultural shift towards making quality the organising principle of NHS services, by embedding quality at the heart of commissioner-provider discussions. It is an important level, supplementing Quality Accounts, to ensure that local quality improvement priorities are discussed and agreed at board level within, and between organisations. It makes a providers income dependent on locally agreed quality and innovation goals - 1.5% in 2010/11 on top of actual outturn value (0.5% available for Regional CQUIN indicators and 1% available for local CQUIN indicators). During 2010/11 the total value of the Community CQUIN scheme equated to £862.81K against the Community contract for NHS Barnsley Care Services Direct Community). The inclusion of the CQUIN framework as a nationally mandated element in Quality Accounts will ensure that:

- The relationship between Quality Accounts and commissioning for quality and innovation schemes is clear to local organisations and the public, helping system alignment.
- You are required to be transparent about whether you are agreeing quality improvement and innovation goals with your commissioners, and earning part of your income by making improvements.
- You are required to make full details of the quality improvement goals agreed with your commissioners available electronically to ensure transparency and help schemes improve over time.

Use of the CQUIN framework indicates that you are actively engaged in quality improvements with your commissioners some of which may impact beyond the boundaries of the organisation and improve patient pathways across local health economy. Whether agreement has been reached with commissioners about quality improvement goals is therefore an indicator of your contribution to quality improvement in local health services more broadly. Both you and your commissioner need to be aware of the wider restraints of health inequalities and associated risk factors, and how they, through their commissioning for quality improvements, can be addressed.

The tables overleaf show the detail of the regional and locally agreed indicators for 2010/11. The Trusts progress on achieving these indicators is monitored on a quarterly basis and the 2010/11 results will be available in next year's quality accounts. Work to develop indicators for the 2011/12 CQUIN scheme on a local level is currently on-going.

**Table 11: Regional Commissioning for Quality and Innovation (CQUIN) 2010/11 - COMMUNITY**

| Regional CQUIN – Goal | Quality Domain | Indicators |
|---|---|---|
| **A. Increase the number of personalised care plans that assist patients in experiencing seamless responsive care in accordance with their wishes. Agencies will have a single common vehicle to improve communication and understanding. Reducing admissions and improving health outcomes** | Clinical Effectiveness<br>Patient Experience | • Improving and sharing personalised care plans for patients with Long Term condition |
| **B. Patients and carers will be able to expect the highest possible standards of end of life care** | Clinical Effectiveness<br>Patient Experience | • Improving the quality of palliative care |
| **C. Improve safeguarding of vulnerable children by improving the number of level 3 staff having supervision** | Patient Safety | • Use of Common Assessment Framework (CAF) for vulnerable children |
| **D. Level of Child Protection Supervision given to Level 3 staff who have regular contact with children, young people and parents Level 3 staff who have regular contact with children, young people and parents** | Patient Safety | • An uptake of Child Protection Supervision |
| **E. Improve the focus on the care of the patients, in line with Essence of Care. Use of validated nutritional indicator screening tool will be encouraged to reduce rates of malnutrition and associated adverse outcomes** | Clinical Effectiveness<br>Patient Experience<br>Patient Safety | • Care and compassion - Nutrition |
| **F. Improvement in pressure ulcer prevention and management in line with Essence of Care – Ward and Non Ward Services** | Clinical Effectiveness<br>Patient Experience<br>Patient Safety | • Care and compassion – Pressure Ulcers |

**Table 12: Regional Commissioning for Quality and Innovation (CQUIN) 2010/11 – MENTAL HEALTH**

| Regional CQUIN – Goal | Quality domain | Indicators |
|---|---|---|
| **A. Improve safeguarding of vulnerable adults by improving the number of level 2 staff having supervision** | Patient Safety | • Use of Common Assessment Framework (CAF) for vulnerable children |
| **B. Accommodation**<br>**Mental Health Primary and Secondary Care** | Patient Experience<br>Patient Safety | • Increasing social inclusion<br>• Supporting national standards<br>• Effective discharge planning |
| **C. Employment** | Patient Experience | • Increasing percentage of adults in contact with Mental Health Services<br>• Supporting National Standard |
| **D. Improving Quality related to accessing Psychological Therapies** | Patient Experience<br>Clinical Effectiveness | • Identified by commissioners as a service priority.<br>• To increase the number of successful discharges from people in receipt of IAPT. |

**Table 13: Local Commissioning for Quality and Innovation (CQUIN) 2010/11 - COMMUNITY**

| Local CQUIN – Goal | Quality domain | Indicators |
|---|---|---|
| **A. Supporting women to quit smoking and remain quit during pregnancy and after delivery. Providing ongoing support for the woman and her family for the length of her pregnancy** | Patient Safety | • Conversion rates for pregnant women smokers to improve to regional average or above.<br>• Number of pregnant women quitting via the stop smoking service to increase based on 2009/10 levels.<br>• Percentage of pregnant women who quit as CO2 validated.<br>• Percentage of pregnant women smokers supported by the service not known or lost to follow up. |
| **B. Reduce incidence of and mortality from falls** | Patient Safety | • Reduction in the number of multiple falls. |
| **C. Improve patient satisfaction** | Clinical Effectiveness | • Patient Experience Survey based on the Care Quality Commission's five questions for Acute Trusts. |
| **D. Reduce sickness and absence levels of staff** | Innovation | • Sickness and absence levels of staff to be monitored quarterly using 2008/09 – 2009/10 data. |
| **E. Enable people to regain their level of independence after receiving intermediate care intervention** | Clinical Effectiveness | • 60% of all Intermediate Care interventions will achieve a 20% improvement of Barthel score from commencement to termination of intervention. |

**Table 14: Local Commissioning for Quality and Innovation (CQUIN) 2010/11 – MENTAL HEALTH**

| Local CQUIN – Goal | Quality domain | Indicators |
|---|---|---|
| **A. Patient Experience** | Clinical Effectiveness | • To improve patient satisfaction. Patient Satisfaction Survey regarding care co-ordination and care planning. |
| **B . Reduce sickness and absence levels of staff** | Innovation | • Sickness and absence levels of staff to be monitored quarterly using 2008/09 – 2010/11 data. |

### 2.2.5 What others say about the provider

#### 2.2.5(i) Care Quality Commission (CQC)

The CQC are the independent watchdog of health and adult social care services across England. To be registered with the CQC NHS Barnsley Care Services Direct had to formally declare that we are meeting all the new CQC registration regulations, including all the essential standards of safety and quality.

NHS Barnsley Care Services Direct is required to register with the Care Quality Commission to provide services legally. Care Services Direct registration status is (registration from April 2010) 'registered without any imposed compliance conditions'. The CQC has not taken enforcement action against NHS Barnsley Care Services Direct during the last year.

### 2.2.6 Data quality

#### 2.2.6(i) NHS Number and General Medical Practice Code Validity

**Data Quality**

NHS Barnsley Care Services Direct submitted records during the period 1 April 2010 to 31 December 2010 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

**Community:** The percentage of records in the published data which included the patient's valid NHS Number was:

- 100% for admitted patient care
- 100% for out patient care

The percentage of records in the published data which included the patient's valid general Medical Practice Code was:

- 100% for admitted patient care
- 100% for out patient care

**Mental Health:** The percentage of records in the published data which included the patient's valid NHS Number was:

- 99.9% for admitted patient care
- 95.84% for out patient care

The percentage of records in the published data which included the patient's valid general Medical Practice Code was:

- 99.93% for admitted patient care
- 99.99% for out patient care

#### 2.2.6(ii) Information Governance Toolkit attainment levels

NHS Barnsley Care Services Direct score for 2010/11 for information quality and records management assessed using the information governance toolkit was 66%.

#### 2.2.6 (iii) Payment by Results (PbR)

PbR is a transparent, rules – based financial system which rewards Trust's efficiency and supports patient choice. NHS Barnsley Care Services Direct was not subject to the PbR clinical coding audit during the reporting period by the Audit Commission.

# PART 3

### 3.1 Review of Quality Performance

On the following pages we present data that is relevant to local stakeholders (people who take an interest in the organisation). These have been determined by quality priorities and identified indicators.

NHS Barnsley Care Services Direct (Community) identified three key quality priority areas:

- Medicines Management
- Personalised Care
- Zero Tolerance of Avoidable Healthcare Associated Infection – C Difficile

NHS Barnsley Care Services Direct (Mental Health) identified three key quality priority areas:

- Medicines Management
- AIMS Accreditation
- Refurbishment of Ward 6 and its integration into the acute care pathway

NHS Barnsley Care Services Direct has specified a selection of indicators against each of the above priority areas and the three quality domains – clinical effectiveness, patient experience, and patient safety. The underlying reason for the choice of each indicator is described and, wherever possible, historical and benchmarked data is referenced.

Commissioning for Quality and Innovation (CQUIN) payment framework makes a proportion of providers' income conditional on quality and innovation. CQUIN indicators are extremely important parts of any quality plan as they represent what the commissioners have identified as demonstrating quality, according to local needs. However, as CQUINS have been fully identified and already reported in part 2 of this quality account they are not repeated in part 3.

National targets reported to the regulators (Monitor and CQC) are also important indicators of service quality. Information relating to national targets is shown earlier in this account under 'What others say about the Trust' and so is not repeated in part 3.

There are 5 local quality indicators identified within this section of the Quality Account against community services. Of these:

- 3 relate to clinical effectiveness
- 3 relate to patient experience
- 4 relate to patient safety

It should be noted that some indicators relate to more than one of the three quality domains.

**Table 15: How the local quality indicators relate to the quality domains - COMMUNITY**

| Indicator | Related Domain | | |
|---|---|---|---|
| | Clinical Effectiveness | Patient Experience | Patient Safety |
| Staff undertaking Medicines with Respect or Medicines Management training | ✓ | | ✓ |
| Medicines cards completed in line with policy | | | ✓ |
| Patients answering that they got enough information about their medications | | ✓ | |
| Personalised Care provision to patients at the End of Life | ✓ | ✓ | ✓ |
| Reduction in C Difficile infections | ✓ | ✓ | ✓ |

There are 5 local quality indicators identified within this section of the Quality Account against Mental Health services. Of these:

- 3 relate to clinical effectiveness
- 3 relate to patient experience
- 4 relate to patient safety

**Table 16:**
**How the local quality indicators relate to the quality domains – MENTAL HEALTH**

| Indicator | Related Domain | | |
|---|---|---|---|
| | Clinical Effectiveness | Patient Experience | Patient Safety |
| Staff undertaking Medicines with Respect or Medicines Management training | ✓ | | ✓ |
| Medicines cards completed in line with policy | | | ✓ |
| Patients answering that they got enough information about their medications | | ✓ | |
| AIMS Accreditation process | ✓ | ✓ | ✓ |
| Refurbishment of Ward 6 currently nearing completion, providing inpatient care to older adults compromising 5 male and 5 female beds | ✓ | ✓ | ✓ |
| On completion Ward 6 will be integrated into the existing acute care pathway currently provided by the Oakwell Centre | ✓ | ✓ | ✓ |

### 3.1.1 Priority Area – Medicines Management

**Rationale for indicators inclusion -**
**To improve patient safety and patient experience it is important that patients get the right medicines and the right information about their medicines. Appropriate staff training is also required for this.**

| Local Quality Indicator | Quality Domain | Construction | Minimum Target 2010/11 | Performance 2009/10 | Performance 2010/11 | Achieved 2010/11 |
|---|---|---|---|---|---|---|
| Staff undertaking Medicines with Respect or Medicines Management training | Clinical Effectiveness Patient Safety | Annual figure | 90% | Unknown | 15% | No |
| Medicines cards completed in line with policy | Patient Safety | From annual audit | 90% | 30% | (Still waiting for results) | No |
| Patients answering that they got enough information about their medications | Patient Experience | Patient survey | 90% | Unknown | 77.8% | No |

### 3.1.2 Priority Area – Personalised Care

**Rationale for indicators inclusion –**
**Patients and carers will be able to expect the highest standards of personalised care at all times and at the End of Life.**

| **Local Quality Indicator – Personalised Care provision to patients at the End of Life** | |
|---|---|
| **Quality Domain - Clinical Effectiveness, Patient Experience, Patient Safety** | |
| **Construction** | **Achieved 2010/11** |
| Provision of personalised care plans in the format of: **Preferred Priorities for Care (PPC)** document for patients who are identified as being in the last 6 – 12 months of life. | Extensive consultation preceded the PPC launch event, attended by 73 people, on 23 September 2010. This included a comprehensive piece of work with ARENA (Barnsley Arena is a Carer and Service User led organisation), to ensure local public consultation and the correlation between end of life care planning tool and locally developed advance care planning tools.<br><br>The total number of PPC's used since the launch where notification has been received is 91. Notification has been received that 34 of these patients have since died. 30 of these patients died in their preferred place i.e. 88% of patients dying with a PPC died in their preferred place of care. The document has been introduced in a 2 phased plan.<br><u>Phase 1</u><br>To raise awareness and understanding of this plan, encouraging the staff who had communication skills and confidence to use this tool and to raise awareness of its existence with other staff. This has involved significant amounts of training with staff from all sectors including hospital and community nurses from a range of disciplines; care home staff, medics, AHPs and social care. These sessions have included formal sessions including the launch event and local end of life education programmes and smaller sessions of in house training as indicated below :<br>Dementia and end of life care study day PPC and advance care planning session attended by 47 people.<br>45 additional smaller training sessions attended by a total of 274 people. Complimenting this training is numerous individualised support sessions provided in practice situations to generalist staff to use the documents.<br><u>Phase 2</u><br>It is planned to begin Phase 2 within the next months and this training will include communications skills training to support the use of the plan again to a wide range of generalist staff. |
| **Last days of life care pathways**<br><br>Last Days of Life Care Pathway for those patients who are identified as being in the last days of life.<br><br>Last Days of Life Care Pathway to be used in community settings for 28% of all deaths. | Last days of life care pathway is being used and promoted across all sectors.<br><br>In the community setting the number of patients dying on a last days of life care pathway for the first three quarters of 2010/11 is 27%.<br><br>Continuous training, audit and update around these pathways is being provided.<br><br>In house training is provided by the end of life care team across the district; the number of sessions provided since April 2010 is 47 with a total of 227 attendees. 47 with a total of 227 attendees The last days of life care pathways across Barnsley have now been updated and are in line with Version 12 of the pathway from Liverpool and the pathway from Liverpool and will be launched in April and May 2011. |

### 3.1.3 Priority Area – Zero Tolerance of Avoidable Healthcare Associated Infection- C Difficile

**Rationale for indicators inclusion -**
**High priority to continue to reduce avoidable Healthcare Associated Infection - C Difficile**

| **Local Quality Indicator - Reduction in C Difficile infections** | |
|---|---|
| **Quality Domain - Clinical Effectiveness, Patient Experience, Patient Safety** | |
| **Construction** | **Achieved 2010/11** |
| **Prudent antibiotic prescribing**<br><br>• Reviewed antibiotics usage and antibiotic prescribing as part of consultant Microbiology ward round.<br><br>• Included stop dates on antibiotic prescriptions<br><br>• Conducted antimicrobial prescribing policy audit.<br><br>**Correct Hand hygiene**:<br><br>• Implemented cleanyourhands campaign Trust wide.<br><br>• Conducted hand hygiene audits<br><br>• Provided hand hygiene training to all new starters and on a mandatory basis. | Appropriate prescribing of antibiotics is an important quality issue. Over prescribing and inappropriate selection of antibiotics results in an increase in antibiotic resistance with potentially serious public health consequences. The organisation has an active programme in place to contain the level and the range of antibiotic prescribing. Antibiotic, individual patient assessment and monitoring is conducted by the infection prevention and control and, in conjunction with the Consultant microbiologist.<br>A weekly Consultant Microbiologist ward round at Mount Vernon Hospital has taken place since May 2009. The direct communication between clinicians has greatly improved the management/treatment of patients with infectious conditions. The ward round has contributed to a reduction in the over usage of antibiotics and the duration of antibiotic treatment. It has also enhanced the knowledge of the staff working on the wards, nursing and medical staff alike. The patients also feel empowered in that they received face to face feedback from the Microbiologist.Antimicrobial education session for medical and nursing staff delivered to Mount Vernon Hospital staff by Consultant Microbiologist, to increase awareness and compliance. Antimicrobial prescribing guidelines have been implemented, in which some restrictions were imposed on the use of broad spectrums antibiotics. This is achieved through the work of the Lead Pharmacist and Medicine Management Team. The Lead Pharmacist undertook an antibiotic prescribing audit for the Trust. Results were favourable and demonstrate a reduction in the prescribing of restricted antibiotics. The organisation has established a RCA overview panel, which looks at each individual C Difficile positive case. The purpose of the panel is to monitor all RCA investigations, identify trends and initiate actions. Actions and learning's from these meetings are feedback to the Community Infection Control Committee.<br><br>Continued support and awareness is given from the Trust for the NPSA cleanyourhands Campaign. It focuses both on staff (to raise awareness and facilitate good hand hygiene practice) and patients (to similarly raise awareness and the expectation that staff should be cleaning their hands before and after touching every patient). Numerous promotional materials are being used and new initiatives promoted by the campaign have also been initiated within the Trust i.e. - 5 moments for hand hygiene at point of care. The five moments identifies when hand hygiene should occur during patient care to prevent the transmission of infection. An awareness session for Hand Hygiene Week - May 2010 took place within the organisation. In conjunction with this session a quiz was undertaken by which the winners won Fob watches, encouraging and raising awareness of bare below the elbow initiative with encourages compliance with hand hygiene. The Trust is committed to reducing healthcare associated infection, thus being totally committed to the campaign. Hand hygiene remains a high priority activity for the Trust. Ward areas have hand hygiene champions, to enhance the continuous improvement and compliance with hand hygiene which is everyone's business. Hand Hygiene observational audits are and were undertaken by numerous staff groups including staff working in inpatient rehabilitation, outpatients and community settings. The process includes review of proforma, organisation and arrange audits with service leads, perform the audits and provide feedback, which includes action plans that are monitored, by the internal mechanisms of the organisation. The hand hygiene observational audits at Mount Vernon Hospital are continuing and are on a regular programme with quarterly reports being produced and feedback through the Modern Matron/ Ward Managers. These audits are now being introduced and extended to other in patient wards, namely Beamshaw Ward, Clark Ward and the Community Rehabilitation and Respite Unit. |

Mandatory training levels have been reported and the uptake was good. A 75% target trajectory for mandatory training is set by to organisation.

Mandatory hand hygiene training has been consistently achieved each month.

Averaging out at 80% trained over the year. The IP&CT participate in the Trust's Induction Programme for new starters and have achieved 100% compliance with provision of this service.

Number of training session conducted by infection prevention and control team 09/10:

| Type of session | Number of sessions |
|---|---|
| Induction | 17 |
| Hand hygiene drop in session | 8 |
| Infection control/hand hygiene/MRSA C difficile combined | 17 |
| Infection Control/Hand hygiene | 10 |

Number of training session conducted by infection prevention and control team 09/10:

| Type of session | Number of sessions |
|---|---|
| Induction | 20 |
| Mandatory training | 4 |
| Hand hygiene drop in session | 5 |
| Infection control/hand hygiene | 19 |
| Hand Hygiene for Patient, Public Involvement representatives | 1 |
| Healthcare associated infection training | 2 |
| Hand Hygiene auditors training | 1 |
| Champions training | 1 |

As part of the Infection prevention and control team's continuous review and pursuit of other innovative ways/methods of delivering effective infection control and hand hygiene training, the team produced two hand hygiene DVDs (short films): Safe Hands (adult) and Safe Hands 4 Kids (children and younger persons). These DVDs have been utilised and well received within the organisation and also for other partnership in working groups. The adult hand hygiene DVD is regularly put onto personnel's computers to view and continue to raise awareness and compliance.

| | |
|---|---|
| **Environmental decontamination:**<br><br>• Reviewed deep clean team schedule.<br><br>• Deep clean and decontaminate rooms after discharge on patients with C Difficile infection.<br><br>• Completed matrons environmental check list and action findings. | Premises where healthcare is provide should be suitable for purpose, kept clean and maintained in good physical repair. The schedule is to ensure effective clean on a continuous programme.<br><br>100% compliance with the deep cleaning of rooms after discharge of C Difficile positive patients, to prevent cross contamination.<br>The Matrons Charter Group developed and produced a weekly ward environment check list. This check list is being used at Mount Vernon Hospital, Community Rehabilitation and Respite Unit, Kendray and Learning Disabilities. The purpose of the check list is to conduct a weekly walk round to monitor cleanliness, safety and tidiness identify any minor works/repairs that required reporting and to monitor to completion. Quarterly reports are being produced and these are being reported through the CSD Infection Control Committee.<br>A stand alone monitoring service has been developed by the Facilities Business Unit, which enables the cleanliness of the Trust estate to be audited in line with National Standards for Cleanliness. Quarterly and Annual reports are tabled at Infection Control meetings and Care Service Executive Group. |
| **Policies / procedures:**<br><br>• Have robust infection prevention and control policies and procedure in place.<br><br>• Monitor the implementation Decontamination Policy. | All policies are reviewed on a ratifying schedule and marinated to national standards and with evidence based practice.<br><br>Monitoring of the decontamination policy: Audits included in the annual plan.<br><br>**Decontamination of Medical Devices Audit**<br>The impact of Healthcare Associated Infections requires actions to reduce the risk of transmission along the patient/service user journey. One of these actions is to improve the cleanliness and decontamination of near-patient equipment. Decontamination is the combination of processes (including cleaning, disinfection and sterilisation) used to make a re-usable item safe for further use on patients and handling by staff. The effective decontamination of re-usable medical devices is essential in reducing the risk of transmission of infectious agents. The audit is required to assess the cleanliness and decontamination of near-patient equipment. The audit was organisational wide with the aim to improve the cleanliness and decontamination of near-patient equipment, help reduce the risk of healthcare-associated infection (HCAI) cross contamination, embed the importance of cleaning into everyday work routine of the ward**,** improve patient confidence. Feedback and action plans were produced and actioned.<br><br>**Decontamination Audit**<br>The impact of Healthcare Associated Infections requires actions to reduce the risk of transmission along the patient/service user journey. One of these actions is to adequately manage and maintain suitable equipment and devices in which infections can be prevented and controlled. NHS Barnsley outlines their commitment to this in the NHS Barnsley Policy on the Selection, Procurement, Commissioning, Use and Monitoring of Medical Devices and the NHS Barnsley Care Services Direct Decontamination Policy 2010 which states that “Medical devices must be effectively cleaned, disinfected or sterilised, to protect the health and safety of staff, patients and any other who is involved in the inspection, service, repair or transportation of medical devices or equipment”.<br>This audit was conducted to assess the trust’s employee’s knowledge of the policy, including the single use symbol, where to access it, and how to manage decontamination within the organisation and by doing so aims to improve the safety and wellbeing of staff, patients, visitors and contractors. The aim is to understand staff knowledge of the Decontamination Policy and how to access it, ascertain staff knowledge and recognition of the single use symbol found on medical devices, help reduce the risk of healthcare-associated infection (HCAI) cross-contamination, and embed the importance of cleaning into the everyday work routine of the department. Feedback and action plans were produced and actioned. |

### 3.1.4 Priority Area – AIMS

**Rationale for indicators inclusion –**
**Patients and carers will be able to expect the highest standards of personalised care at all times and at the End of Life.**

| **Local Quality Indicator – Accreditation process** | |
|---|---|
| **Quality Domain - Clinical Effectiveness, Patient Experience, Patient Safety** | |
| **Construction** | **Ongoing 2011/12** |
| Accreditation for Inpatient Mental Health Services (AIMS) standards for inpatient ward – working age adults | The actual accreditation standards drawn from key documents are to help wards demonstrate achievement and compliance with the Healthcare Commission's "Standards for Better Health" and support implementation of NICE guidelines.<br><br>They have been subject to extensive consultation with all professional groups involved in the provision of acute inpatient mental health services and with service users and their representative organisations. Standards are reviewed annually and applied each year during self and peer-reviews processes.<br><br>There are 5 topics covered by the AIMS standards these are as follows:<br><br>• General standards<br>• Timely and Purposeful Admission<br>• Safety<br>• Environment and Facilities<br>• Therapies and Activities<br><br>There are several phases to be attained commencing with self-review, peer-review and then accreditation.<br><br>**OBJECTIVES**<br><br>The purpose of the AIMS is to improve the cared provided by acute mental health wards. The achievement process completed by:<br><br>• Accrediting acute inpatient mental health ward<br>• Creating a national network to support staff through:<br>- A data base of standards for acute inpatient care<br>- The AIMS peer-reviews process<br>- Email discussion group<br>• Maintaining a data base of standards for acute inpatient care |

### 3.1.5 Priority Area – Refurbishment of Ward 6 and its integration into the Acute Care Pathway

**Rationale for indicators inclusion -**
**High priority to continue to reduce avoidable Healthcare Associated Infection - C Difficile**

| **Local Quality Indicator – Refurbishment of the Ward** | |
|---|---|
| **Quality Domain - Clinical Effectiveness, Patient Experience, Patient Safety** | |
| **Construction** | **Ongoing 2011/12** |
| Refurbishment of Ward 6<br><br>Strategies and Frameworks to be implemented to ensure transition into the acute care pathway already in existence | The refurbishment process for Ward 6 is currently nearing completion.<br><br>The Ward will provide acute inpatient care to functional older age adults, hosting 5 male and 5 female beds in line with single sex accommodation.<br><br>On completion the ward will go through a process of strategies and frameworks be integrated into the existing pathway provided by inpatient mental health services located at the Oakwell Centre.<br><br>Priorities for the unit will include:<br>• Timely discharge through planned interventions from admission to meet patient need<br>• Improved communication between different interfaces, promoting a more seamless approach<br>• Defining roles and responsibilities of staff on Acute Wards under new ways of working#<br>• Reduction in length of stay – outcome measure<br>• Reduction in delayed discharge – outcome measure early discharge – IHTT – outcome measure<br>• Length of time to contact Care Coordinator and arrange necessary care review – process measure<br>• Reduced length of stay<br>• Focused care<br>• Effective communication#<br>• Cared Coordinators engaged<br>• Promoting early discharge through IHTT working effectively<br>• Seamless process<br><br>Reconfiguring Care Pathways and Packages will in turn lead to:<br>• Bed occupancy<br>• Reducing cost: out of area/early discharge<br>• Payment by results<br>• Quality Care Standards: Productive Ward/Star Wards<br>• Aims<br>• Accommodation<br>• Activity monitoring |

### 3.2 Statement from Commissioners (NHS Barnsley)

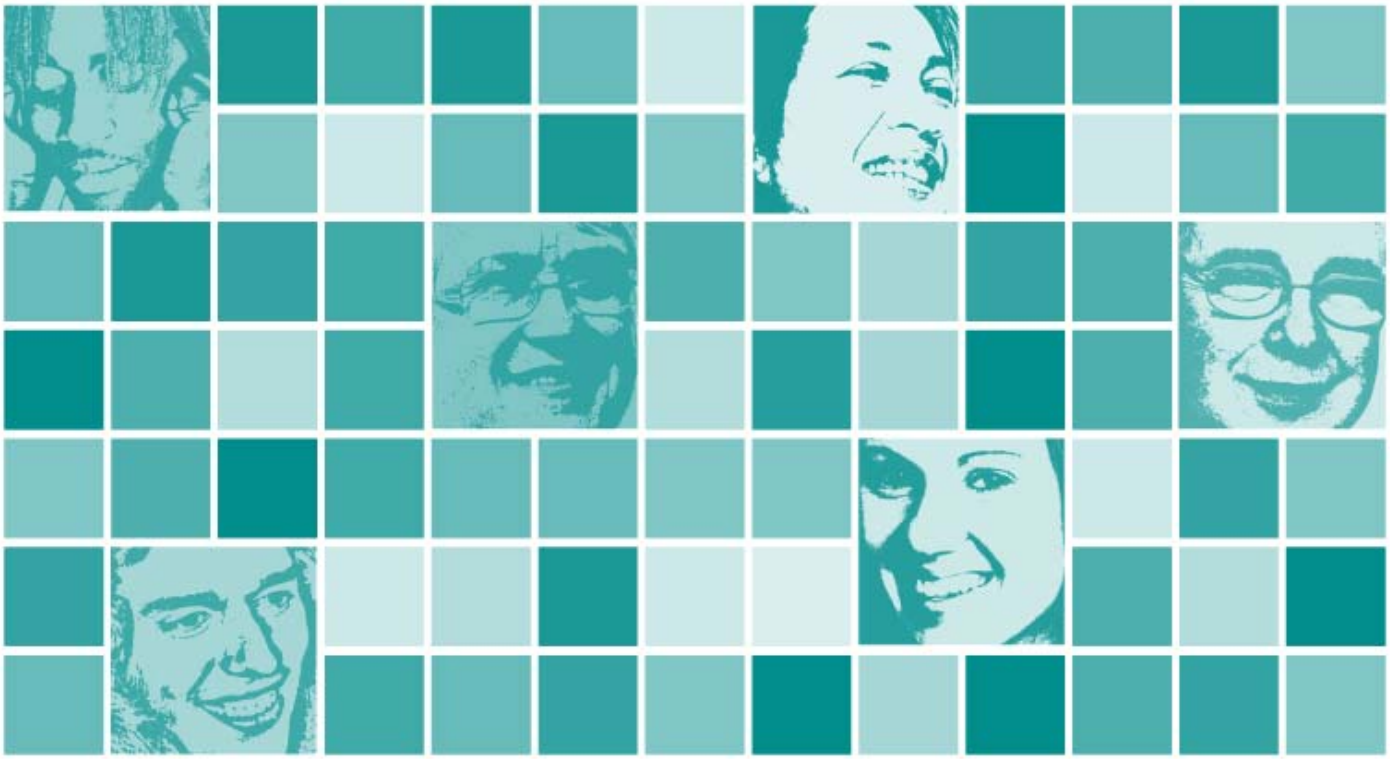
**At the time of this statement Barnsley Care services direct was the provider arm of NHS Barnsley (PCT).**

On behalf of NHS Barnsley, we confirm that we feel the presented quality account for Care Services Direct 2010/2011 is an accurate account.

However, we would like to see further commentary on the work that has been done to implement guidelines and recognised good practice across CSD, particularly given the significant amount of work done in relation to clinical audit to demonstrate good clinical care.

We welcome the commitment of CSD in identifying their quality priorities for 2011/2012, which, whilst clearly challenging, will seek to improve patients experience, safety and the effectiveness of the care they receive.

# Part 5



## 5.1 Your comments are welcome

We hope you have found our quality account interesting and easy to understand.

We'd love to hear what you thought of it, so please let us have your comments by using the contact details below. Please also let us know if you would like to get involved in helping us decide our priorities for improving quality.

This report can be made available in a variety of formats, available on request.

### And stay in touch!

Would you like to stay in touch with the Trust by becoming a member and receiving our Trust magazine?

To become a member get in touch with us at:

Communications
Fieldhead
Ouchthorpe Lane
Wakefield WF1 3SP
comms@swyt.nhs.uk
01924 327689

### Our website

The Trust's website gives more information about the Trust and the quality of our services, as well as information about how to look after your wellbeing.

You can also sign up as a member of the Trust on our website, read the latest issue of our magazine, Like minds, and view our latest news and performance information.

Do all this at **www.southwestyorkshire.nhs.uk**

English If you would like help understanding this information, please call 0800 587 2108.

Urdu اگر آپ کو اس معلومات کے سمجھنے کے لئے مدد کی ضرورت ہو تو براہِ مہربانی ٹیلیفون نمبر 0800 587 2108 پر رابطہ کریں۔

Pahari جے تُساں کی ہس معلومات کی سمجھݨے نی لوڑ اہہ تہ مہربانی کری فون نمبر 0800 587 2108 اپر رابطہ کری کینو۔

Punjabi ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਸਮਝਣ ਲਈ ਮਦਦ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ ਕ੍ਰਿਪਾ ਕਰਕੇ 0800 587 2108 'ਤੇ ਟੈਲੀਫੋਨ ਕਰੋ।

Gujarati જો તમારે આ માહિતી સમજવામાં મદદ જોઇતી હોય તો, મહેરબાની કરી 0800 587 2108 નંબર પર ફોન કરો.

Bangla এই তথ্য বুঝতে আপনার সাহায্যের দরকার হলে দয়া করে 0800 587 2108 নাম্বারে ফোন করুন।

Chinese 如果您需要幫助來了解這些資料，請致電 0800 587 2108 查詢。

Polish Jeśli chcesz pomocy ze zrozumieniem tej informacji proszę dzwonić na 0800 587 2108.

Kurdish ئەگەر پێویستت بەیارمەتی هەیە تا لەم زانیارییانە تێبگەیت، تکایە زەنگ بدە بە ژمارەی تەلەفۆنی 0800 587 2108

Farsi اگرشما برای فهمیدن این اطلاعات به کمک نیاز دارید، لطفابا تلفن شماره 0800 587 2108 تماس بگیرید.

Arabic إذا كنت ترغب في المساعدة على فهم هذه المعلومات ، يرجى الاتصال بالرقم: 0800 587 2108

French En cas de difficultés pour lire cette information, veuillez appeler le 0800 587 2108.

Data entered below will be used throughout the workbook:

| | |
|---|---|
| Trust name: | South West Yorkshire Partnership NHS Foundation Trust |
| This year | 2010/11 |
| Last year | March 2010 |
| This year ended | 31 March 2011 |
| Last year ended | 31 March 2010 |
| This year commencing: | 1 April 2010 |

## STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

The NHS Act 2006 states that the chief executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilites of Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the Accounting Officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed the South West Yorkshire Partnership NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the 2006 Act and are prepared on an accruals basis and must give a true and fair view of the state of affairs of South West Yorkshire Partnership NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Financial Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

.....Chief Executive 6.6.11 .....Date

## STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Services Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure of the Trust for that period. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury

- make judgements and estimates which are reasonable and prudent

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

.....Chief Executive 6.6.11 .....Date

A Farnell .....Director of Finance 6.6.11 .....Date

## INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF MEMBERS AND BOARD OF DIRECTORS OF SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

We have audited the financial statements of South West Yorkshire Partnership NHS Foundation Trust for the year ended 31 March 2011 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers Equity and the related notes 1 to 37. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

This report is made solely to the Council of Members and Board of Directors ("the Boards") of South West Yorkshire Partnership NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

### Respective responsibilities of the accounting officer and auditors

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code of NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

### Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

### Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2011 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

### Opinion on other matters prescribed by the National Health Service Act 2006

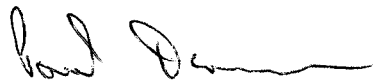
In our opinion:

- the information given in the Annual Report, pages 1 to 63, for the financial year for which the financial statements are prepared is consistent with the financial statements.

**Matters on which we are required to report by exception**
We have nothing to report in respect of the following matters where the National Health Service Act 2006 requires us to report to you if, in our opinion:

- proper practices have not been observed in the compilation of the financial statements; or
- the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources

**Certificate**
We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts.



Paul Thomson ACA (Senior Statutory Auditor)
For and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Leeds, UK
6 June 2011

**STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2011**

| | note | Year Ended 31 March 2011 £000 | 11 Months Ended 31 March 2010 £000 |
|---|---|---|---|
| **Revenue** | | | |
| Operating Income from continuing operations | 5 | 128,347 | 113,898 |
| Operating Expenses of continuing operations | 6 | (123,680) | (111,431) |
| **Operating surplus (deficit)** | | **4,667** | **2,467** |
| **Finance costs:** | | | |
| Finance income | 10 | 194 | 88 |
| PDC Dividends payable | | (1,535) | (1,569) |
| **NET FINANCE COSTS** | | **(1,341)** | **(1,481)** |
| **Surplus/(Deficit) from continuing operations** | | **3,326** | **986** |
| **SURPLUS/(DEFICIT) FOR THE YEAR** | | **3,326** | **986** |
| **Other comprehensive income** | | | |
| Impairments | | 0 | (5,995) |
| **TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR** | | **3,326** | **(5,009)** |

The notes numbered 1 to 37 form part of these accounts.

| STATEMENT OF FINANCIAL POSITION | note | 31 March 2011 £000 | 31 March 2010 £000 |
|---|---|---|---|
| **Non-current assets** | | | |
| Intangible assets | 13 | 91 | 144 |
| Property, plant and equipment | 14 | 55,798 | 52,200 |
| Investment Property | 15 | 280 | 270 |
| **Total non-current assets** | | **56,169** | **52,614** |
| **Current assets** | | | |
| Inventories | 19 | 49 | 42 |
| Trade and other receivables | 20 | 2,374 | 1,525 |
| Cash and cash equivalents | 21 | 18,218 | 16,325 |
| **Total current assets** | | **20,641** | **17,892** |
| **Current liabilities** | | | |
| Trade and other payables | 22 | (9,770) | (8,762) |
| Provisions | 25 | (453) | (161) |
| Other liabilities | 22 | (543) | (561) |
| **Total current liabilities** | | **(10,766)** | **(9,484)** |
| **Total assets less current liabilities** | | **66,044** | **61,022** |
| **Non-current liabilities** | | | |
| Provisions | 25 | (3,084) | (1,466) |
| Other liabilities | 22 | (294) | (216) |
| **Total non-current liabilities** | | **(3,378)** | **(1,682)** |
| **Total assets employed** | | **62,666** | **59,340** |
| **Financed by (taxpayers' equity)** | | | |
| Public Dividend Capital | | 41,991 | 41,991 |
| Revaluation reserve | | 7,604 | 7,884 |
| Donated Asset Reserve | | 31 | 31 |
| Other reserves | | 5,220 | 5,220 |
| Income and expenditure reserve | | 7,820 | 4,214 |
| **Total taxpayers' equity** | | **62,666** | **59,340** |

.....Chief E: 06-Jun-11

**STATEMENT OF CHANGES IN TAXPAYERS' EQUITY**

| | Total | Public Dividend Capital | Revaluation Reserve | Donated Assets Reserve | Other Reserves | Income and Expenditure Reserve |
|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 |
| **At 1 April 2010** | **59,340** | 41,991 | 7,884 | 31 | 5,220 | 4,214 |
| Surplus/(deficit) for the year | **3,326** | 0 | 0 | 0 | 0 | 3,326 |
| Asset disposals | **0** | 0 | (183) | 0 | 0 | 183 |
| Other reserve movements | **0** | 0 | (97) | 0 | 0 | 97 |
| **Taxpayers' Equity at 31 March 2011** | **62,666** | **41,991** | **7,604** | **31** | **5,220** | **7,820** |

| | Total | Public Dividend Capital | Revaluation Reserve | Donated Assets Reserve | Other Reserves | Income and Expenditure Reserve |
|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 |
| **At 1 May 2009** | **64,351** | 41,991 | 13,881 | 31 | 5,220 | 3,228 |
| Surplus/(deficit) for the year | **986** | 0 | 0 | 0 | 0 | 986 |
| Impairments | **(5,995)** | 0 | (5,995) | 0 | 0 | 0 |
| Other reserve movements | **(2)** | 0 | (2) | 0 | 0 | 0 |
| **Taxpayers' Equity at 31 March 2010** | **59,340** | **41,991** | **7,884** | **31** | **5,220** | **4,214** |

**STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2011**

| | note | Year Ended 31 March 2011 £000 | 11 Months Ended 31 March 2010 £000 |
|---|---|---|---|
| **Cash flows from operating activities** | | | |
| Operating surplus/(deficit) from continuing operations | | 4,667 | 2,467 |
| **Operating surplus/(deficit)** | | **4,667** | **2,467** |
| **Non-cash income and expense:** | | | |
| Depreciation and amortisation | 6 | 2,074 | 1,759 |
| Impairments | | 175 | 4,062 |
| Amortisation of government grants | | 0 | (3) |
| (Increase)/Decrease in Trade and Other Receivables | 20 | (838) | 3,564 |
| (Increase)/Decrease in Inventories | 19 | (7) | 7 |
| Increase/(Decrease) in Trade and Other Payables | 22 | 413 | 1,393 |
| Increase/(Decrease) in Other Liabilities | 22 | 74 | 8 |
| Increase/(Decrease) in Provisions | 25 | 1,910 | 91 |
| **NET CASH GENERATED FROM/(USED IN) OPERATIONS** | | **8,468** | **13,348** |
| **Cash flows from investing activities** | | | |
| Interest received | | 194 | 88 |
| Purchase of intangible assets | | 0 | (80) |
| Purchase of Property, Plant and Equipment | | (5,223) | (3,631) |
| **Net cash generated from/(used in) investing activities** | | **(5,029)** | **(3,623)** |
| **Cash flows from financing activities** | | | |
| PDC Dividend paid | | (1,546) | (1,741) |
| **Net cash generated from/(used in) financing activities** | | **(1,546)** | **(1,741)** |
| **Increase/(decrease) in cash and cash equivalents** | | **1,893** | **7,984** |
| **Cash and Cash equivalents at start of period** | | 16,325 | 8,341 |
| **Cash and Cash equivalents at 31 March** | | **18,218** | **16,325** |

## Notes to the Accounts - 1. Accounting Policies

**1 Accounting Policies**

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

**1.1 Accounting convention**

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

**1.2 Acquisitions and discontinued operations**

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

**1.3 Critical accounting judgements and key sources of estimation uncertainty**

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

**1.3.1 Critical judgements in applying accounting policies**

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

There were no critical judgements made during the reporting period.

The Trust discloses the critical judgements made by the Trust's management as required by IAS 1.113.

**1.3.2 Key sources of estimation uncertainty**

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Information about the key assumptions for the Trust is disclosed, as required by IAS 1.116. Disclosures includes the nature of the assumption and the carrying amount of the asset/liability at the end of the reporting period and may include sensitivity of the carrying amount to the assumptions, expected resolution of uncertainty and range of possible outcomes within the next financial year, and an explanation of changes to past assumptions if the uncertainty remains unresolved.

The Trust has a challenging cost saving programme approved by the Board; a number of the posts to be dis-established have substantive members of staff in post which will result in these staff being made redundant. This affects 65 whole time equivalent posts and the Trust has estimated the associated redundancy costs and made provision for them in 2010/11.

Following advice from the Independent Accountants the Trust has made an accrual of £300k to provide for unforeseen costs arising from the provider arm transfers agreed by the Trust Board in 2010/11.

**Notes to the Accounts - 1. Accounting Policies (Continued)**

**1.3.3 Provisions:**

The Trust has a number of long term provisions. The carrying amount of these provisions is estimated based on assumptions such as discount rates used, future changes in prices and estimates of costs. A change in estimates could have a material impact on the carrying amount of these provisions.

In respect of provisions for Pensions relating to other staff, the uncertainty as to amounts and timings relate to the remaining lifespan of each individual. Provisions are reviewed periodically against Government Actuary's Department (GAD) life table profiles.

In respect of Legal claims, the uncertainty as to amounts and timings relate to the time taken to determine whether or not the Trust is liable (estimates are made in conjunction with the NHS Litigation Authority) and if so, what the value of the liability will be.

Other Provisions include: Injury benefit provisions and Equal pay provisions. Injury Benefits relate to injury benefits payable by the NHS Pensions Agency, the uncertainty as to amounts and timings relate to the remaining lifespan of each individual. The Equal Pay provision is for legal costs only, as the NHS is not presently making a provision in terms of the claims. The key uncertainty in regards to this, relates to the success of other claims put forward as test cases by individuals. The outcome of these claims could lead to a material change in the provisions at some undetermined future date.

**1.4 Revenue**

The main source of revenue for the Trust is from Primary Care Trusts, which are government funded commissioners of NHS health and patient care. Revenue is recognised in the period in which services are provided.
Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

**1.5 Expenditue on employee benefits**

**Short-term employee benefits**

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

**Retirement benefit costs**

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

Employers pension cost contributions are charged to operating expenses as and when they become due.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

**Notes to the Accounts - 1. Accounting Policies (Continued)**

**1.6 Expenditure on other goods and services**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

**1.7 Property, plant and equipment**

**Recognition**

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

**Valuation**

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

There was no revaluation of estate during 2010/11 as the carrying value on the Statement of Financial Position does not differ materially from fair value as assessed by the District Valuer.

**Notes to the Accounts - 1. Accounting Policies (Continued)**

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

**Subsequent expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

**1.8 Intangible assets**

**Recognition**

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

**Notes to the Accounts - 1. Accounting Policies (Continued)**

**Measurement**

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

**1.9 Depreciation, amortisation and impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives or, where shorter, the lease term.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

**1.10 Borrowing Costs**

Borrowing costs are recognised as expenses as they are incurred.

**1.11 Donated assets**

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to the donated asset reserve. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations and impairments are taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to offset the expenditure. On sale of donated assets, the net book value is transferred from the donated asset reserve to retained earnings.

**Notes to the Accounts - 1. Accounting Policies (Continued)**

### 1.12 Government grants

Government grants are grants from government bodies other than revenue from NHS bodies for the provision of services. Revenue grants are treated as deferred income initially and credited to income to match the expenditure to which it relates.

Where the grant is used to fund capital expenditure the grant is held as deferred income and released to operating income over the life of the asset in a manner consistent with the depreciation charge for that asset.

### 1.13 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings. For donated and government-granted assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal account so that no profit or loss is recognised in income or expenses. The remaining surplus or deficit in the donated asset or government grant reserve is then transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

### 1.14 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

**The Trust as lessee**

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit. The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated. These separate components are assessed as to whether they are operating or finance leases.

**Notes to the Accounts - 1. Accounting Policies (Continued)**

**The Trust as lessor**

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

**1.15 Inventories**

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

**1.16 Cash and cash equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

**1.17 Provisions**

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.9% in real terms for voluntary early retirement and injury benefit and 2.2% in real terms, for the remaining provisions.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arsing from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

**1.18 Clinical negligence costs**

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed in the notes to the accounts.

**Notes to the Accounts - 1. Accounting Policies (Continued)**

### 1.19 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

### 1.20 EU Emissions Trading Scheme

EU Emission Trading Scheme allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from the government grant reserve. The provision is settled on surrender of the allowances. The asset, provision and government grant reserve are valued at fair value at the end of the reporting period.

### 1.21 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingencies are disclosed at their present value.

### 1.22 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

**Financial assets at fair value through profit and loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the Trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

There were no embedded derivatives at fair value through profit and loss during the reporting period.

**Notes to the Accounts - 1. Accounting Policies (Continued)**

**Held to maturity investments**

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

**Available for sale financial assets**

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

**Loans and receivables**

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.
Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques, including reviewing recent arms length market transactions.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset or, when appropriate, to the initial fair value of the financial asset.

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly, or through a provision for impairment of receivables

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

**1.23 Financial liabilities**

Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

**Notes to the Accounts - 1. Accounting Policies (Continued)**

**Financial guarantee contract liabilities**

Financial guarantee contract liabilities are subsequently measured at the higher of:

The premium received (or imputed) for entering into the guarantee less cumulative amortisation.

The amount of the obligation under the contract, as determined in accordance with IAS 37 *Provisions, Contingent Liabilities and Contingent Assets.*

**Financial liabilities at fair value through profit and loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.
There were no embedded derivatives at fair value through profit and loss during the reporting period.

**Other financial liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of those costs.

**1.24 Value Added Tax**

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

**1.25 Foreign Exchange**

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

Non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of transaction. Non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined. Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

**1.26 Third party assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 35 to the accounts.

**Notes to the Accounts - 1. Accounting Policies (Continued)**

**1.27 Public Dividend Capital (PDC) and PDC dividend**

Public dividend capital represents taxpayers' equity in the NHS Foundation Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and cash balances with the Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. From 1 April 2009, the dividend payable is based on the actual average relevant net assets for the year instead of forecast amounts.

**1.28 Losses and Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Foundation Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

**1.29 Subsidiaries**

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust's or where the subsidiary's accounting date is before 1 January or after 30 June.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

For 2010/11, in accordance with the directed accounting policy from the Secretary of State, the Trust does not consolidate the NHS charitable funds for which it is the corporate trustee.

**1.30 Associates**

Material entities over which the Trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the Trust's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the Trust's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the Trust from the entity.

Associates that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

**1.31 Joint ventures**

Material entities over which the Trust has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for by equity method.

Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

**1.32 Joint operations**

Joint operations are activities undertaken by the Trust in conjunction with one or more other parties but which are not performed through a separate entity. The Trust records its share of the income and expenditure; gains and losses; assets and liabilities; and cashflows.

**1.33 Accounting standards and amendments issued but not yet adopted**

The following standards and updates have been published by the International Accounting Standards Board adopted but are not required to be followed until after the current reporting period.

IFRS 7 Financial Instruments: Disclosures - amendment.
IFRS 9 Financial Instruments.
IAS 12 Income Taxes amendment.
IAS 24 (Revised) 'Related Party Disclosures'.
Annual Improvements 2010.
IFRIC 14 amendment.
IFRIC 19 'Extinguishing financial liabilities with Equity Instruments'.

**1.34 Transfers of financial assets**

There were none at the time these accounts were prepared.

**1.35 Going Concern**

The Trust Board has inherently considered the matter of the Trust as a going concern through its ongoing assessment of the resources needed to ensure it continues in operational existence for the foreseeable future. A medium term financial plan (3 years) was presented to and adopted by the Board in May 2010. This was subject to independent review by Monitor, the FT regulator, and shows the surplus and cash position for the organisation for April 2010 to March 2013. In addition the Trust has prepared a long term financial model (5 years) in support of the proposed acquisition of provider services from NHS Barnsley. This was reviewed and approved by the Board January 2011; these plans illustrate the Trust's on-going financial viability. For this reason, the Trust continues to adopt the going concern basis in preparing the accounts.

**2. Pooled budget**

The Trust has no pooled budgets.

**3. Operating segments**

The Trust has a single operating segment, Healthcare.

**4. Income generation activities**

The Trust does not undertake any significant income generation activities.

**5 OPERATING INCOME**

| **5.1 OPERATING INCOME (by classification)** | **Year Ended 31 March 2011 Total £000** | **11 Months Ended 31 March 2010 Total £000** |
|---|---|---|
| **Income from Activities** | | |
| Block Contract income | 119,834 | 106,652 |
| Other non-protected clinical income | 904 | 726 |
| **Total income from activities** | **120,738** | **107,378** |
| | | |
| **Other operating income** | | |
| Research and development | 29 | 21 |
| Education and training | 1,617 | 1,477 |
| Other | 5,963 | 5,022 |
| **Total other operating income** | **7,609** | **6,520** |
| | | |
| **TOTAL OPERATING INCOME** | **128,347** | **113,898** |

**5.2 Private patient income**

The Trust earned no income from private patients in 2010/11 or in the 11 months ending 31 March 2010.

**5.3 Operating lease income**

The Trust earned no income from operating leases in 2010/11 or in the 11 months ending 31 March 2010.

| **5.4 OPERATING INCOME (by type)** | **Year Ended 31 March 2011 Total £000** | **11 Months Ended 31 March 2010 Total £000** |
|---|---|---|
| **Income from activities** | | |
| Primary Care Trusts | 117,113 | 104,075 |
| Local Authorities | 3,622 | 3,284 |
| Non NHS: Other | 3 | 19 |
| **Total income from activities** | **120,738** | **107,378** |
| | | |
| **Other operating income** | | |
| Research and development | 29 | 21 |
| Education and training | 1,617 | 1,477 |
| Other | 5,963 | 5,022 |
| **Total other operating income** | **7,609** | **6,520** |
| | | |
| **TOTAL OPERATING INCOME** | **128,347** | **113,898** |

Revenue is mostly from the supply of services, revenue from the sale of goods and services is not material.

## 6 Operating Expenses

### 6.1 Operating Expenses

| | Year Ended 31 March 2011 £000 | 11 Months Ended 31 March 2010 £000 |
|---|---|---|
| Services from NHS Foundation Trusts | 10 | 83 |
| Services from NHS Trusts | 21 | 32 |
| Services from other NHS Bodies | 3 | 2 |
| Purchase of healthcare from non NHS bodies | 561 | 741 |
| Employee Expenses - Executive directors | 1,269 | 976 |
| Employee Expenses - Non-executive directors | 126 | 124 |
| Employee Expenses - Staff | 91,182 | 81,652 |
| Drug costs | 1,919 | 1,926 |
| Supplies and services - clinical (excluding drug costs) | 1,472 | 1,429 |
| Supplies and services - general | 2,973 | 3,060 |
| Establishment | 3,798 | 3,320 |
| Research and development | 124 | 47 |
| Transport | 1,021 | 829 |
| Premises | 11,456 | 9,181 |
| Increase / (decrease) in bad debt provision | 8 | 10 |
| Depreciation on property, plant and equipment | 2,021 | 1,725 |
| Amortisation on intangible assets | 53 | 34 |
| Impairments of property, plant and equipment | 185 | 4,037 |
| Audit fees | | |
| audit services - statutory audit | 70 | 96 |
| audit services - regulatory reporting | 0 | 18 |
| Other auditors remuneration | | |
| Clinical negligence | 188 | 139 |
| Legal fees | 215 | 91 |
| Consultancy costs | 403 | 122 |
| Training, courses and conferences | 630 | 418 |
| Patient travel | 23 | 27 |
| Car parking & Security | 126 | 184 |
| Redundancy | 2,280 | 0 |
| Early retirements | (36) | 41 |
| Hospitality | 55 | 39 |
| Publishing | 41 | 27 |
| Insurance | 149 | 150 |
| Other services, eg external payroll | 21 | 55 |
| Losses, ex gratia & special payments | 107 | 4 |
| Other | 1,206 | 812 |
| **Total Operating Expenses** | **123,680** | **111,431** |

### 6.2 Auditor Remuneration and Liability

There is no limitation on the Auditors Liability in 2010/11 or for the 11 months ending 31 March 2010.

### 6.3 The late payment of commercial debts (interest) Act 1998

There were no late payments of commercial debts in 2010/11 or in the 11 months ending 31 March 2010.

### 6.4 Discontinued operations

The Trust had no discontinued operations during the period.

### 6.5 Corporation Tax

The Trust had no Corporation Tax expense during the period.

## 7. Employee costs and numbers

### 7.1 Employee costs

| | Year Ended 31 March 2011 | | |
|---|---|---|---|
| | **Total** | **Permanently Employed** | **Other** |
| | **£000** | **£000** | **£000** |
| Salaries and wages | 76,241 | 67,919 | 8,322 |
| Social Security Costs | 5,410 | 4,898 | 512 |
| Pension costs - defined contribution plans | | | |
| Employers contributions to NHS Pensions | 9,076 | 8,569 | 507 |
| Termination benefits | 2,280 | 2,280 | 0 |
| Agency/contract staff | 1,724 | 0 | 1,724 |
| **Employee benefits expense** | **94,731** | **83,666** | **11,065** |

| | 11 Months Ended 31 March 2010 | | |
|---|---|---|---|
| | **Total** | **Permanently Employed** | **Other** |
| | **£000** | **£000** | **£000** |
| Salaries and wages | 67,927 | 61,979 | 5,948 |
| Social Security Costs | 4,837 | 4,539 | 298 |
| Pension costs - defined contribution plans | | | |
| Employers contributions to NHS Pensions | 8,048 | 7,730 | 318 |
| Termination benefits | 0 | 0 | 0 |
| Agency/contract staff | 1,857 | 0 | 1,857 |
| **Employee benefits expense** | **82,669** | **74,248** | **8,421** |

The board has approved a cost saving programme which will result in 65 post being made redundant and an accrual of £1,893k has been included in the above termination benefits for 2010/11.

**7. Employee costs and numbers (continued)**

**7.2 Average number of people employed**

| | Year Ended 31 March 2011 | | |
|---|---|---|---|
| | **Total** | **Permanently Employed** | **Other** |
| | **Number** | **Number** | **Number** |
| Medical and dental | 128 | 82 | 46 |
| Administration and estates | 418 | 405 | 13 |
| Healthcare assistants and other support staff | 635 | 615 | 20 |
| Nursing, midwifery and health visiting staff | 822 | 822 | 0 |
| Scientific, therapeutic and technical staff | 232 | 229 | 3 |
| Social care staff | 19 | 19 | 0 |
| Bank and agency staff | 109 | 0 | 109 |
| **Total** | **2,363** | **2,172** | **191** |

| | 11 Months Ended 31 March 2010 | | |
|---|---|---|---|
| | **Total** | **Permanently Employed** | **Other** |
| | **Number** | **Number** | **Number** |
| Medical and dental | 129 | 85 | 44 |
| Administration and estates | 406 | 400 | 6 |
| Healthcare assistants and other support staff | 657 | 618 | 39 |
| Nursing, midwifery and health visiting staff | 840 | 840 | 0 |
| Scientific, therapeutic and technical staff | 217 | 205 | 12 |
| Social care staff | 20 | 20 | 0 |
| Bank and agency staff | 79 | 0 | 79 |
| **Total** | **2,348** | **2,168** | **180** |

Unit of measure is whole time equivalent (WTE).

**7.3 Employee benefits**

There were no employee benefits in 2010/11 or in the 11 months ending 31 March 2010.

**7.4 Staff sickness absence**

| | **Year Ended 31 March 2011** | **11 Months Ended 31 March 2010** |
|---|---|---|
| | **Number** | **Number** |
| Total days lost (short term) | 27,729 | 22,480 |
| Total staff years | 2,285 | 1,895 |
| Average working days lost | 12.1 | 10.9 |

This information although based on Trust data is supplied for the accounts by the Department of Health.

**7.5 Management costs**

| | **Year Ended 31 March 2011** | **11 Months Ended 31 March 2010** |
|---|---|---|
| Management costs £000 | 6,467 | 5,725 |
| Income £000 | 128,347 | 113,898 |
| Percentage of Management Costs to Income | 5.0 | 5.0 |

The management costs have been calculated in line with Department of Health guidance and definitions.

**7.6 Early retirements due to ill health**

During the year there were 6 early retirements from the NHS Foundation Trust agreed on the grounds of ill-health (5 during the 11 month period to 31 March 2010). The estimated additional pension liabilities of these ill-health retirements will be £318k (£352k for the 5 retirements in the period ending 31 March 2010). The cost of these ill-health retirements is borne by the NHS Business Services Authority - Pensions Division.

**7. Employee costs and numbers (continued)**

**7.7 Staff exit packages**

Three redundancies were actioned by the Trust during the accounting period. The details of these are disclosed below.

The exit packages here were made either under nationally agreed arrangements or local arrangements approved by the Remuneration and Terms of Service Committee for which Treasury approval was required.

| | 31 March 2011 | | |
|---|---|---|---|
| | Number of compulsory redundancies | Number of other departures agreed | Total number of exit packages by cost band |
| **Exit package cost band** | | | |
| £10,001 - £25,000 | 1 | - | 1 |
| £25,001 - £50,000 | 1 | - | 1 |
| £300,001 - £350,000 | 1 | - | 1 |
| **Total number of exit packages by type** | **3** | **0** | **3** |
| **Total resource cost (£000's)** | **387** | **0** | **387** |

1 payment in the £300,001 - £350,000 band relates to an employee's entitlement to additional pension as a result of redundancy. This was in line with terms and conditions of employment.
Staff exit packages for 2009/10 totalled £0.

## 8. Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.pensions.nhsbsa.nhs.uk. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

**a) Full actuarial (funding) valuation**

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

**b) Accounting valuation**

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2008, is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2008 with summary global member and accounting data.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

**8. Pension costs (continued)**

**c) Scheme provisions**

The scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

The scheme provides the opportunity to members to increase their benefits through money purchase additional voluntary contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made.

**9. Operating leases**

**9.1 As lessee**

The Trust has three types of Operating Lease, these are, for Photocopiers, Vehicles and Property.
Photocopiers are on an OGC negotiated contract with five year lease terms.

Vehicles are on a PASA NHS master lease agreement with typically three year terms.

Property is on commercial arms length contracts, at the end of the accounting period there were nine lease properties, all with different Landlords. The rental periods range from one to thirteen years.

There are no contingent rents or sublease payments due or received.

| **Operating lease payments** | **Year Ended 31 March 2011** | **11 Months Ended 31 March 2010** |
|---|---|---|
| | **£000** | **£000** |
| Minimum lease payments | 1,776 | 1,375 |
| | **1,776** | **1,375** |

| **Future minimum lease payments due** | **Year Ended 31 March 2011** | **11 Months Ended 31 March 2010** |
|---|---|---|
| | **£000** | **£000** |
| Payable: | | |
| Not later than one year | 1,478 | 855 |
| Between one and five years | 3,558 | 1,182 |
| After 5 years | 5,332 | 474 |
| Total | **10,368** | **2,511** |

| 10. Finance Income | Year Ended 31 March 2011 £000 | 11 Months Ended 31 March 2010 £000 |
|---|---|---|
| Interest on loans and receivables | 194 | 88 |
| **Total** | **194** | **88** |

The Trust had no interest on impaired financial assets included in finance income in 2010/11 or in the 11 months ending 31 March 2010.

**11. Finance Costs - interest expense**

The Trust incurred no finance costs in 2010/11 or in the 11 months ending 31 March 2010.

| 12. Impairment of assets (PPE & intangibles) | Year Ended 31 March 2011 £000 | 11 Months Ended 31 March 2010 £000 |
|---|---|---|
| Loss or damage from normal operations | 185 | 0 |
| Changes in market price | 0 | 10,032 |
| **Total Impairments** | **185** | **10,032** |

## 13 Intangible assets

| 13.1 Intangible assets 2010/11 | Total | Software licences (purchased) |
|---|---|---|
| | £000 | £000 |
| **Gross cost at start of period for new FT's** | **355** | 355 |
| **Cost or Valuation at 31 March 2011** | **355** | **355** |
| | | |
| **Amortisation at start of period for new FT's** | **211** | 211 |
| Provided during the year | **53** | 53 |
| **Amortisation at 31 March 2011** | **264** | **264** |
| | | |
| **Net book value** | | |
| NBV - Purchased at 31 March 2011 | **91** | 91 |
| **NBV total at 31 March 2011** | **91** | **91** |

| 13.2 Intangible assets 2009/10 | Total | Software licences (purchased) |
|---|---|---|
| | £000 | £000 |
| **Gross cost at start of period for new FT's** | **275** | 275 |
| Additions - purchased | **80** | 80 |
| **Gross cost at 31 March** | **355** | **355** |
| | | |
| **Amortisation at start of period for new FT's** | **177** | 177 |
| Provided during the year | **34** | 34 |
| **Amortisation at 31 March** | **211** | **211** |
| | | |
| **Net book value** | | |
| NBV - Purchased at 31 March 2010 | **144** | 144 |
| **NBV total at 31 March** | **144** | **144** |

### 13.2 Intangible assets

Intangible Assets are all purchased software licences and are depreciated over the life of the licence. There has been no revaluation of these assets.
No intangible Assets were acquired by Government Grant.

### 13.3 Economic Lives of Intangible Assets

Intangible Assets are depreciated over a maximum life of four years.

**14.1 Property, plant and equipment 31 March 2011**

| | Total | Land | Buildings excluding dwellings | Assets under Construction & POA | Plant & Machinery | Transport Equipment | Information Technology | Furniture & Fittings |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Cost or valuation at start of period** | **56,881** | 11,946 | 41,255 | 102 | 2,041 | 104 | 1,048 | 385 |
| Additions - purchased | **5,804** | 0 | 4,446 | 774 | 254 | 21 | 211 | 98 |
| Reclassifications | **0** | 0 | 439 | (672) | 233 | 0 | 0 | 0 |
| Revaluations | **(304)** | 0 | (304) | 0 | 0 | 0 | 0 | 0 |
| **Cost or Valuation at 31 March 2011** | **62,381** | **11,946** | **45,836** | **204** | **2,528** | **125** | **1,259** | **483** |
| | | | | | | | | |
| **Accumulated depreciation at start of period** | **4,681** | 741 | 1,713 | 0 | 1,226 | 26 | 689 | 286 |
| Provided during the year | **2,021** | 0 | 1,676 | 0 | 139 | 16 | 175 | 15 |
| Impairments | **185** | 0 | 185 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | **0** | 0 | 3 | 0 | (3) | 0 | 0 | 0 |
| Revaluation surpluses | **(304)** | 0 | (304) | 0 | 0 | 0 | 0 | 0 |
| **Accumulated depreciation at 31 March 2011** | **6,583** | **741** | **3,273** | **0** | **1,362** | **42** | **864** | **301** |
| **Net book value** | | | | | | | | |
| **Net book value at 31 March 2011** | | | | | | | | |
| NBV - Owned at 31 March 2011 | **55,767** | 11,205 | 42,532 | 204 | 1,166 | 83 | 395 | 182 |
| NBV - Donated at 31 March 2011 | **31** | 0 | 31 | 0 | 0 | 0 | 0 | 0 |
| **NBV total at 31 March 2011** | **55,798** | **11,205** | **42,563** | **204** | **1,166** | **83** | **395** | **182** |

**14.2 Property, plant and equipment 31 March 2010**

| | Total | Land | Buildings excluding dwellings | Assets under Construction & POA | Plant & Machinery | Transport Equipment | Information Technology | Furniture & Fittings |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Cost or valuation at start of period** | **67,481** | 13,526 | 47,710 | 450 | 2,225 | 97 | 2,954 | 519 |
| Additions - purchased | **3,332** | 0 | 387 | 2,504 | 368 | 7 | 66 | 0 |
| Impairments | **(5,995)** | (1,580) | (4,415) | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | **0** | 0 | 2,961 | (2,852) | (109) | 0 | 0 | 0 |
| Revaluations | **(5,164)** | 0 | (5,164) | 0 | 0 | 0 | 0 | 0 |
| Disposals | **(2,773)** | 0 | (224) | 0 | (443) | 0 | (1,972) | (134) |
| **Cost or valuation at 31 March** | **56,881** | **11,946** | **41,255** | **102** | **2,041** | **104** | **1,048** | **385** |
| | | | | | | | | |
| **Accumulated depreciation at start of period** | **6,856** | 0 | 2,375 | 0 | 1,546 | 14 | 2,515 | 406 |
| Provided during the year | **1,725** | 0 | 1,461 | 0 | 92 | 12 | 146 | 14 |
| Impairments | **4,037** | 741 | 3,260 | 0 | 36 | 0 | 0 | 0 |
| Reclassifications | **0** | 0 | 5 | 0 | (5) | 0 | 0 | 0 |
| Revaluation surpluses | **(5,164)** | 0 | (5,164) | 0 | 0 | 0 | 0 | 0 |
| Disposals | **(2,773)** | 0 | (224) | 0 | (443) | 0 | (1,972) | (134) |
| **Accumulated depreciation at 31 March** | **4,681** | **741** | **1,713** | **0** | **1,226** | **26** | **689** | **286** |
| **Net book value** | | | | | | | | |
| | | | | | | | | |
| **Net book value** | | | | | | | | |
| NBV - Owned at 31 March 2010 | **52,169** | 11,205 | 39,511 | 102 | 815 | 78 | 359 | 99 |
| NBV - Donated at 31 March 2010 | **31** | 0 | 31 | 0 | 0 | 0 | 0 | 0 |
| **NBV total at 31 March 2010** | **52,200** | **11,205** | **39,542** | **102** | **815** | **78** | **359** | **99** |

**14.3 Property, plant and equipment (cont.)**

There were no properties held at existing use value that had an open market value that was materially different to its existing use value.

**14.4 Economic Lives of Property, Plant and Equipment**

| | Max Life Years |
|---|---|
| Land | 0 |
| Buildings excluding dwellings | 89 |
| Plant & Machinery | 10 |
| Transport Equipment | 6 |
| Information Technology | 5 |
| Furniture & Fittings | 10 |

**14.5 Analysis of property, plant and equipment**

| | Total | Land | Buildings excluding dwellings | Assets under Construction & POA | Plant & Machinery | Transport Equipment | Information Technology | Furniture & Fittings |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Net book value 31 March 2011** | | | | | | | | |
| NBV - Protected assets at 31 March 2011 | **34,463** | 7,375 | 27,088 | 0 | 0 | 0 | 0 | 0 |
| NBV - Unprotected assets at 31 March 2011 | **21,335** | 3,830 | 15,475 | 204 | 1,166 | 83 | 395 | 182 |
| **Total at 31 March 2011** | **55,798** | **11,205** | **42,563** | **204** | **1,166** | **83** | **395** | **182** |

| | Total | Land | Buildings excluding dwellings | Assets under Construction & POA | Plant & Machinery | Transport Equipment | Information Technology | Furniture & Fittings |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Net book value 31 March 2010** | | | | | | | | |
| NBV - Protected assets at 31 March 2010 | **34,999** | 7,375 | 27,624 | 0 | 0 | 0 | 0 | 0 |
| NBV - Unprotected assets at 31 March 2010 | **17,201** | 3,830 | 11,918 | 102 | 815 | 78 | 359 | 99 |
| **Total at 31 March 2010** | **52,200** | **11,205** | **39,542** | **102** | **815** | **78** | **359** | **99** |

**14.6 Finance Leases**

The Trust holds no finance lease assets.

## 15 Investments

### 15.1 Investments - Carrying Value

| | Property* 31 March 2011 £000 | Property* 31 March 2010 £000 |
|---|---|---|
| **At Carrying Value** | | |
| Balance at Beginning of Period | 270 | 295 |
| Impairments recognised in expenses | 0 | (25) |
| Gain on investment | 10 | 0 |
| **Balance at End of Period** | **280** | **270** |

* The Trust has no other investments.

The Property was revalued using Modern Equivalent Asset methodology. The last valuation was undertaken by the District Valuer as at the 31st of December 2010.

The net gain as a result of the valuation was charged to expenditure.

### 15.2 Investment Property expenses

The Trust incurred no investment property expense in 2010/11 or in the 11 months ending 31 March 2010.

## 16. Non-current assets held for sale and assets in disposal groups

### 16.1 Non-current assets held for sale

There were no non-current assets held for sale in 2010/11 or in the 11 months ending 31 March 2010.

### 16.2 Liabilities in disposal groups

There were no liabilities in disposal groups in 2010/11 or in the 11 months ending 31 March 2010.

## 17. Other assets

There were no other assets in 2010/11 or in the 11 months ending 31 March 2010.

## 18. Other Financial Assets

There were no other financial assets in 2010/11 or in the 11 months ending 31 March 2010.

## 19. Inventories

### 19.1. Inventories

| | 31 March 2011 £000 | 31 March 2010 £000 |
|---|---|---|
| Materials | 49 | 42 |
| **Total** | **49** | **42** |

### 19.2 Inventories recognised in expenses

| | 11 Months Ended 31 March 2011 £000 | 31 March 2010 £000 |
|---|---|---|
| Write-down of inventories recognised as an expense | (7) | 7 |
| **Total** | **(7)** | **7** |

## 20. Trade and other receivables

### 20.1 Trade and other receivables

| | 31 March 2011 £000 | 31 March 2010 £000 |
|---|---|---|
| **Current** | | |
| NHS Receivables | **647** | **408** |
| Other receivables with related parties | **425** | **321** |
| Provision for impaired receivables | **(21)** | **(13)** |
| Prepayments | **812** | **685** |
| Accrued income | **414** | **9** |
| PDC receivable | **11** | **0** |
| Other receivables | **86** | **115** |
| **TOTAL CURRENT TRADE AND OTHER RECEIVABLES** | **2,374** | **1,525** |

**The Trust had no non current trade and other receivables as at 31 March 2011 (£0 31 March 2010).**

### 20.2 Provision for impairment of receivables

| | 31 March 2011 £000 | 31 March 2010 £000 |
|---|---|---|
| **Balance at start of period** | 13 | 3 |
| Increase in provision** | 19 | 12 |
| Unused amounts reversed | (11) | (2) |
| **Balance at 31 March** | **21** | **13** |

The Trust provides for all non NHS receivables over 90 days past their due date.

### 20.3 Analysis of impaired receivables

| | 31 March 2011 £000 | 31 March 2010 £000 |
|---|---|---|
| **Ageing of impaired receivables** | | |
| Up to three months | 1 | 2 |
| In three to six months | 17 | 2 |
| Over six months | 3 | 9 |
| **Total** | **21** | **13** |
| | | |
| **Ageing of non-impaired receivables past their due date** | | |
| Up to three months | 542 | 609 |
| In three to six months | 13 | 13 |
| Over six months | 37 | (19) |
| **Total** | **592** | **603** |

### 20.4 Finance lease receivables

South West Yorkshire Partnership NHS Foundation Trust has no finance lease receivables.

## 21. Cash and cash equivalents

| | 31 March 2011 £000 | 31 March 2010 £000 |
|---|---|---|
| **Balance at start of period** | **16,325** | **8,350** |
| Net change in year | 1,893 | 7,975 |
| **Balance at 31 March** | **18,218** | **16,325** |
| | | |
| **Broken down into:** | | |
| Cash at commercial banks and in hand | 30 | 51 |
| Cash with the Government Banking Service | 18,188 | 16,274 |
| **Cash and cash equivalents as in statement of financial position** | **18,218** | **16,325** |
| | | |
| **Cash and cash equivalents as in statement of cash flows** | **18,218** | **16,325** |

The Trust held £312k cash and cash equivalents at 31 March 2011 (£335k at 31 March 2010) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

## 22. Trade and other payables

### 22.1 Trade and other payables

| | Total 31 March 2011 £000 | Total 31 March 2010 £000 |
|---|---|---|
| **Current** | | |
| NHS payables | 1,573 | 1,733 |
| Amounts due to other related parties | 2,260 | 1,938 |
| Trade payables - capital | 750 | 168 |
| Other trade payables | 1,232 | 1,419 |
| Accruals | 3,955 | 3,504 |
| **TOTAL CURRENT TRADE AND OTHER PAYABLES** | **9,770** | **8,762** |

The Trust had no non current trade and other payables as at 31 March 2011 (£0 31 March 2010).

### 22.2 Better Payment Practice Code

| Better Payment Practice Code - measure of compliance | 31 March 2011 Number | 31 March 2011 £000 |
|---|---|---|
| Total Non-NHS trade invoices paid in the year | 17,880 | 21,930 |
| Total Non NHS trade invoices paid within target | 17,646 | 21,600 |
| Percentage of Non-NHS trade invoices paid within target | **99%** | **98%** |
| Total NHS trade invoices paid in the year | 838 | 13,483 |
| Total NHS trade invoices paid within target | 820 | 13,206 |
| Percentage of NHS trade invoices paid within target | **98%** | **98%** |

| | 11 Months Ended 31 March 2010 Number | 11 Months Ended 31 March 2010 £000 |
|---|---|---|
| Total Non-NHS trade invoices paid in the year | 16,312 | 14,682 |
| Total Non NHS trade invoices paid within target | 15,830 | 14,360 |
| Percentage of Non-NHS trade invoices paid within target | **97%** | **98%** |
| Total NHS trade invoices paid in the year | 845 | 14,509 |
| Total NHS trade invoices paid within target | 820 | 14,301 |
| Percentage of NHS trade invoices paid within target | **97%** | **99%** |

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

**22.3 Early retirements detail included in NHS payables**

The Trust has no early retirement costs included in payables as at 31 March 2011 (£0 as at 31 March 2010).

| **22.4 Other liabilities** | **31 March 2011 £000** | **31 March 2010 £000** |
|---|---|---|
| **Current** | | |
| Deferred Income | 540 | 558 |
| Deferred Government Grant | 3 | 3 |
| **TOTAL OTHER CURRENT LIABILITIES** | **543** | **561** |
| **Non-current** | | |
| Deferred Income | 80 | 0 |
| Deferred Government Grant | 214 | 216 |
| **TOTAL OTHER NON CURRENT LIABILITIES** | **294** | **216** |

**22.5 Other Financial Liabilities**

The Trust has no other financial liabilities as at 31 March 2011 (£0 as at 31 March 2010).

**23. Borrowings**

The Trust has no borrowings as at 31 March 2011 (£0 as at 31 March 2010).

**24. Prudential borrowing limit**

The NHS foundation trust is required to comply and remain within a prudential borrowing limit.

This is made up of two elements:

i) the maximum cumulative amount of long-term borrowing. This is set by reference to the four ratio tests set out in Monitor's Prudential Borrowing code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit; and

ii) the amount of an working capital facility approved by Monitor.

Further information of the NHS Foundation Trust Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

The Trust has a maximum long term borrowing limit of £22.0m in 2010/11 (£23.8m 11 month ending 31 March 2010). The Tru did not make any borrowings in during the year.

The Trust has £9.2m of approved working capital facility. The Trust has not made any drawings against this facility.

| | **31 March 2011 £000** | **31 March 2010 £000** |
|---|---|---|
| Total long term borrowing limit set by Monitor | 22,000 | 23,800 |
| Working capital facility agreed by Monitor | 9,200 | 9,200 |
| **Total Prudential Borrowing Limit** | **31,200** | **33,000** |
| **Long term borrowing at 31 March** | **0** | **0** |
| **Working capital borrowing at 31 March** | **0** | **0** |

| | | **2010/11** | |
|---|---|---|---|
| | Actual | Planned | Approved |
| **Financial Ratios** | | | |
| Minimum dividend cover | 4.6 | 3.4 | >1 |

| | | **2009/10** | |
|---|---|---|---|
| | Actual | Planned | Approved |
| **Financial Ratios** | | | |
| Minimum dividend cover | 5.3 | 4.9 | >1 |

## 25. Provisions

| | Current | | Non-current | |
|---|---|---|---|---|
| | 31 March 2011 £000 | 31 March 2010 £000 | 31 March 2011 £000 | 31 March 2010 £000 |
| Pensions relating to other staff | 50 | 0 | 542 | 615 |
| Legal claims | 53 | 52 | 203 | 145 |
| Other | | 76 | | |
| Equal Pay | 0 | 0 | 180 | 180 |
| Injury Benefit | 350 | 33 | 2,159 | 526 |
| **Total** | **453** | **161** | **3,084** | **1,466** |

| | Total | Pensions relating to other staff | Legal claims | Other |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| At start of period | 1,627 | 667 | 221 | 739 |
| Change in the discount rate | (99) | (50) | 0 | (49) |
| Arising during the year | 2,347 | 27 | 242 | 2,078 |
| Utilised during the year | (158) | (52) | (73) | (33) |
| Reversed unused | (180) | 0 | (134) | (46) |
| **At 31 March 2011** | **3,537** | **592** | **256** | **2,689** |
| **Expected timing of cash flows:** | | | | |
| Not later than one year; | 453 | 50 | 53 | 350 |
| Later than one year and not later than five years; | 2,287 | 186 | 200 | 1,901 |
| Later than five years. | 797 | 356 | 3 | 438 |
| **Total** | **3,537** | **592** | **256** | **2,689** |

Pensions relating to former directors and staff - these provisions relate to the expected pension payments to former employees. The total value is based upon a standard life expectancy of the former employee. Should this life expectancy not be achieved the value and timing of the payments will be affected. The value of the pension payment is also affected by annual pension increases, determined by the NHS Pensions Agency.

Legal claims - these provisions relate to public and employers liability claims. The value and timing of the payments is uncertain until the claims have been fully investigated and any settlements agreed.

Other - injury benefits are payable by the NHS Pensions Agency. The total value of the provision is based upon a standard life expectancy of the former employee. Should this life expectancy not be achieved the value and timing of the payments will be affected. The value of the pension payment is also affected by annual pension increases, determined by the NHS Pensions Agency.

Other - equal pay relates to provisions for 9 equal pay claims. The provision is for legal costs only as the NHS is not presently making a provision in terms of the claims.

£270K is included in the provisions of the NHS Litigation Authority at 31 March 2011 (£83k at 31 March 2010) in respect of clinical negligence liabilities of the NHS Trust.

## 26. Contingencies

### 26.1 Contingent liabilities

The Trust has no contingent liabilities as at 31 March 2011 (£0 as at 31 March 2010).

### 26.2 Contingent assets

The Trust has no contingent assets as at 31 March 2011 (£0 as at 31 March 2010).

| 27. Revaluation reserve | Total Revaluation Reserve | Revaluation Reserve - property, plant and equipment |
|---|---|---|
| | £000 | £000 |
| **At 1 April 2010** | **7,884** | **7884** |
| Asset disposals | (183) | (183) |
| Other reserve movements | (97) | (97) |
| **Revaluation reserve at 31 March 2011** | **7,604** | **7,604** |
| | **£000** | **£000** |
| **At 1 May 2009** | **13,881** | **13,881** |
| Revaluations | (5,995) | (5,995) |
| Other reserve movements | (2) | (2) |
| **Revaluation reserve at 31 March 2010** | **7,884** | **7,884** |

**28. Finance lease obligations**

South West Yorkshire Partnership NHS Foundation Trust has no finance lease obligations.

**29. Finance lease commitments**

South West Yorkshire Partnership NHS Foundation Trust has not entered into any new finance leases during the period.

**30. Capital commitments**

Contracted capital commitments at the period end not otherwise included in these financial statements:

| | 31 March 2011 £000 | 31 March 2010 £000 |
|---|---|---|
| Property, plant and equipment | 3,045 | 158 |
| **Total** | **3,045** | **158** |

## 31. Financial Instruments

### 31.1 Financial assets

| | Total | Loans and receivables |
|---|---|---|
| | £000 | £000 |
| **Assets as per SoFP** | | |
| Trade and other receivables excluding non financial assets (at 31 March 2011) | **1,148** | 1,148 |
| Cash and cash equivalents (at bank and in hand at 31 March 2011) | **18,218** | 18,218 |
| **Total at 31 March 2011** | **19,366** | **19,366** |
| Trade and other receivables excluding non financial assets (at 31 March 2010) | **831** | 831 |
| Cash and cash equivalents (at bank and in hand at 31 March 2010) | **16,325** | 16,325 |
| **Total at 31 March 2010** | **17,156** | **17,156** |

### 31.2 Financial liabilities

| | Total | Other financial liabilities |
|---|---|---|
| | £000 | £000 |
| **Liabilities as per SoFP** | | |
| Trade and other payables excluding non financial assets (31 March 2011) | **9,770** | 9,770 |
| Provisions under contract (at 31 March 2011) | **3,537** | 3,537 |
| **Total at 31 March 2010** | **13,307** | **13,307** |
| Trade and other payables excluding non financial assets (31 March 2010) | **8,762** | 8,762 |
| Provisions under contract (at 31 March 2010) | **1,627** | 1,627 |
| **Total at 1 May 2009** | **10,389** | **10,389** |

### 31.3 Fair values of financial assets at 31 March 2011

| | Book Value |
|---|---|
| | £000 |
| Other | 18,218 |
| **Total** | **18,218** |

## 32. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with primary care trusts and the way those primary care trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

**Currency risk**
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has negligible exposure to currency rate fluctuations.

**Interest rate risk**
The Trust currently has no long term borrowing. The Trust has a working capital facility of £9.2m with Barclays Bank, with a cost of £46k per annum for the facility. The Trust has not drawn down on this facility in the current period.

**Credit risk**
Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2011 are in receivables from customers, as disclosed in the Trade and other receivables note.

**Liquidity risk**
The Trust's operating costs are incurred under contracts with primary care trusts, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from internally generated resources; future capital expenditure will be funded in the same way or from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

## 33. Events after the reporting period

In connection with the national Transforming Community Services programme and following the receipt of appropriate assurances the Board authorised the Trust to make the following acquisitions:

- On 1 April 2011, community services provided by NHS Wakefield District and NHS Calderdale transferred to the Trust, and

- On 1 May 2011 community and mental health services provided by Care Services Direct, the provider arm of NHS Barnsley, transferred to the Trust.

The annual income of the Wakefield provider arm service is circa £6.5 million and 168 staff were transferred to the Trust as part of the acquisition, while the transferring Calderdale provider services annual income is £3.5 million and 110 staff were transferred. The provider income for the Barnsley provider services totals £86 million and 2,097 staff were transferred to the Trust.

## 34. Private Finance Initiative contracts

South West Yorkshire Partnership NHS Foundation Trust has no Private Finance Initiative Contracts.

## 35. Related party transactions

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with South West Yorkshire Partnership NHS Foundation Trust.

Steven Michael, Chief Executive. Spouse is Trustee of the Harrison Trust, a charitable body supporting mental health in the Wakefield district and was seconded to the role of Director of Provider Development, NHS Yorkshire and the Humber (part time 1 October to 31 January 2011).

Alex Farrell, Deputy Chief Executive/Director of Finance: Spouse is general practitioner based in Beeston, Leeds.

Nisreen Booya, Medical Director is Honorary President of the Support to Recovery (Kirklees mental health charity).

Terry Dutchburn, Director of Business Development and Planning (left the Trust 30 November 2010): Spouse is Assistant Director of Commissioning at NHS Kirklees.

Anne Gregory, Non Executive Director (left the Trust 26 May 2010) is employed by Leeds Metropolitan University which has contracts with the Department of Health, NHS East Midlands, NHS Yorkshire and the Humber, NHS Institute for Innovation and Improvement. Anne is also a Council Member, Chartered Institute of Public Relations (Director) who will seek business with the NHS.

Jan Wilson, Non Executive Director (left the Trust 26 May 2010) is a Lay Chair, Yorkshire Deanery and is a Member of the Regional Sub-Committee, Advisory Committee on Clinical Excellence Awards.

The Trust has also received revenue payments from a number of charitable funds, certain of the Trustees for which are also members of the NHS Trust Board.

The Trust is in line with the NHS as a whole which has a further divergence and is not required to consolidate Funds Held on Trust.

The audited accounts of the Funds Held on Trust are available on request from Dawn Stephenson, Director of Corporate Development, South West Yorkshire Partnership NHS Foundation Trust, Fieldhead, Wakefield, WF1 3SP.

| **35.1 Related Party Transactions** | **Income £000** | **Expenditure £000** |
|---|---|---|
| Value of transactions with other related parties in 2010/11 | | |
| Department of Health | 0 | 214 |
| Other NHS Bodies | 122,426 | 21,504 |
| Other | 4,844 | 18,695 |
| **Total** | **127,270** | **40,413** |

| | **Income £000** | **Expenditure £000** |
|---|---|---|
| Department of Health | 15 | 190 |
| Other NHS Bodies | 108,496 | 20,409 |
| Other | 4,314 | 16,893 |
| **Total** | **112,825** | **37,492** |

| **35.2 Related Party Balances** | **Receivables £000** | **Payables £000** |
|---|---|---|
| Value of balances with other related parties at 31 March 2011 | | |
| Department of Health | 0 | 54 |
| Other NHS Bodies | 1,053 | 2,102 |
| Other | 432 | 2,275 |
| **Total** | **1,485** | **4,431** |

| | **Receivables £000** | **Payables £000** |
|---|---|---|
| Other NHS Bodies | 408 | 1,734 |
| Other | 0 | 1,936 |
| **Total** | **408** | **3,670** |

**36. Losses and Special Payments**

There were 30 cases of losses and special payments (34 during 11 months ending 31 March 2010) totalling £6,848 paid during the year (£4,268 paid during 11 months ending 31 March 2010).

There were no clinical negligence cases where the net payment exceeded £100,000.

There were no fraud cases where the net payment exceeded £100,000.

There were no personal injury cases where the net payment exceeded £100,000.

There were no compensation under legal obligations cases where the net payment exceeded £100,000.

There is currently 1 fruitless payment case (£100,000) that relates to an anticipated fine from the Health and Safety Executive.

## 37 Salary and Pension entitlements of senior managers

### 37.1 Remuneration

The Salary and Pension entitlements of senior managers are set by the 'Remuneration and Terms of Services Committee' which is a sub-committee of the Trust Board. The members of this committee in 2010/11 were:

Joyce Catterick (Chair of the Trust Board), Peter Aspinall (Chair of the Committee until 31 May 2010 and Non-Executive Director of the Trust), Ian Black (Chair of the Committee from 01 June 2010 and Non-Executive Director of the Trust), Jan Wilson (Non-Executive Director of the Trust, left 26 May 2010), Jonathan Jones (member of the Committee from 1 September 2010 and Non-Executive Director of the Trust), Helen Wollaston (Non-Executive Director of the Trust), Steven Michael (Chief Executive) with Alan Davis (Director of Human Resources & Workforce Development) in attendance and Bernie Cherriman-Sykes who is the committee secretary.

The Trust follows national guidance on pay and terms and conditions for Senior Managers and the contracts are substantive contracts with NHS termination arrangements.

| Name and Title | Twelve Months to 31/03/2011 | | | Eleven Months to 31/03/2010 | | |
|---|---|---|---|---|---|---|
| | Salary (bands of £5000) £000 | Other Remuneration (bands of £5000) £000 | Benefits in Kind Rounded to 1 decimal place £000 | Salary (bands of £5000) £000 | Other Remuneration (bands of £5000) £000 | Benefits in Kind Rounded to 1 decimal place £000 |
| Joyce Margaret Catterick, Chair | 40 - 45 | | | 35 - 40 | | |
| Janice Anne Wilson, Non-Executive Director (left 26/05/2010) | 0 - 5 | | | 15 - 20 | | |
| Bernard Fee, Non-Executive Director | 10 - 15 | | | 10 - 15 | | |
| Ian Black, Non-Executive Director | 15 - 20 | | | 15 - 20 | | |
| Peter Aspinall, Non-Executive Director | 15 - 20 | | | 10 - 15 | | |
| Anne Gregory, Non-Executive Director (left 26/05/2010) | 0 - 5 | | | 10 - 15 | | |
| Jonathan Jones, Non-Executive Director (appointed 01/06/2010) | 10 - 15 | | | | | |
| Helen Wollaston, Non-Executive Director | 10 - 15 | | | 5 - 10 | | |
| Steven Peter Michael, Chief Executive | 135 - 140 | | 3.5 | 125 - 130 | | 3.4 |
| Nisreen Hanna Booya, Medical Director | 20 - 25 | 115 - 120 | | 25 - 30 | 150 - 155 | |
| Alan George Davis, Director of Human Resources and Workforce Development | 90 - 95 | | 0.9 | 75 - 80 | | 0.9 |
| Terrence Dutchburn, Director of Business Development and Planning (left 30/11/2010) | 55 - 60 | 360 - 365 | 2.6 | 80 - 85 | | 3.8 |
| Hazel O'Hara, Chief Operating Officer (left 31/01/2010) | | | | 75 - 80 | 45 - 50 | 1.2 |
| John Scampion, Interim Director of Finance (left 04/09/2009) | | | | 55 - 60 | | |
| Alexandra Farrell, Deputy Chief Executive/Director of Finance and Acting Chief Executive (from 01/10/2010 to 31/01/2011) | 100 - 105 | | | 55 - 60 | | |
| Dawn Stephenson, Director of Corporate Development | 125 - 130 | | | 20 - 25 | | |
| Ruth Unwin, Director of Corporate Development (left 31/01/2010) | | | | 60 - 65 | | 7.0 |
| Gillian Green, Acting Director of Nursing, Compliance and Innovation | 80 - 85 | | 0.6 | 25 - 30 | | 0.3 |
| Noreen Young, Director of Nursing, Compliance and Innovation | 80 - 85 | | | 75 - 80 | | 25.9 |
| Cherrine Hawkins, Acting Director of Finance (from 01/10/2010 to 31/01/2011) | 25 - 30 | | | | | |
| Timothy Breedon, District Service Director, Wakefield (appointed 01/11/2010) | 30 - 35 | | | | | |
| Anna Basford, District Service Director, Calderdale and Kirklees appointed (01/11/2010) | 35 - 40 | | 5.1 | | | |
| Adrian Berry, Director of Forensic Services (appointed 01/11/2010) | 10 - 15 | 40 - 45 | 1.1 | | | |

The benefits in kind relate to either staff lease cars or expenses paid in accordance with the Trust's Removal Expenses Policy (which includes provision of accommodation), child care vouchers and relocation expenses.
Other remuneration for Terrence Dutchburn includes £341k of pension enhancements paid to the NHS Pensions Authority as part of an exit package.
Dawn Stephenson was seconded from Mid Yorkshire Hospital Trust during 2010/11.

6.6.11

.....Chief Executive.....Date

**37.2 Pension Benefits**

| Name and title | | Real increase/ (decrease) in pension and related lump sum at age 60 (bands of £2500) £000 | Total accrued pension and related lump sum at age 60 at 31 March 2011 (bands of £5000) £000 | Cash Equivalent Transfer Value at 31 March 2011 £000 | Cash Equivalent Transfer Value at 31 March 2010 £000 | Real Increase in Cash Equivalent Transfer Value £000 | Employers Contribution to Stakeholder Pension Rounded to 1 decimal place £000 |
|---|---|---|---|---|---|---|---|
| Steven Peter Michael, Chief Executive | | 7.5 - 10.0 | 175 - 180 | 694 | 757 | (44) | 0 |
| Nisreen Hanna Booya, Medical Director * | | 5.0 - 7.5 | 325 - 330 | 0 | 1,937 | 0 | 0 |
| Alan George Davis, Director of Human Resources and Workforce Development | | 10.0 - 12.5 | 125 - 130 | 563 | 575 | (8) | 0 |
| Terrence Dutchburn, Director of Business Development and Planning (left 30/11/2010) ** | | 5.0 - 7.5 | 145 - 150 | 0 | 637 | 0 | 0 |
| Alexandra Farrell, Deputy Chief Executive/Director of Finance and Acting Chief Executive (from 01/10/2010 to 31/01/2011) | | 10.0 - 12.5 | 95 - 100 | 392 | 388 | 3 | 0 |
| Dawn Stephenson, Director of Corporate Development (appointed 8/02/2010) | | 7.5 - 10.0 | 175 - 180 | 740 | 784 | (31) | 0 |
| Ruth Unwin, Director of Corporate Development (left 31/01/2010) | | | | | 302 | | 0 |
| Gillian Green, Acting Director of Nursing, Compliance and Innovation | | 17.5 - 20.0 | 105 - 110 | 479 | 438 | 28 | 0 |
| Noreen Young, Director of Nursing, Compliance and Innovation | | 0.0 - 2.5 | 170 - 175 | 795 | 869 | (51) | 0 |
| Cherrine Hawkins, Acting Director of Finance (from 01/10/2010 to 31/01/2011) | | 2.5 - 5.0 | 95 - 100 | 404 | 408 | (1) | 0 |
| Timothy Breedon, District Service Director, Wakefield (appointed 01/11/2010) | | (12.5 - 15.0) | 20 - 25 | 255 | 288 | (9) | 0 |
| Anna Basford, District Service Director, Calderdale and Kirklees (appointed 01/11/2010) | | 2.5 - 5.0 | 60 - 65 | 225 | 232 | (2) | 0 |
| Adrian Berry, Director of Forensic Services (appointed 01/11/2010) | | 5.0 - 7.5 | 165 - 170 | 629 | 654 | (7) | 0 |

* Nisreen Booya was in reciept of pension from 30/09/11 and so the CETV is nil.
** Terrence Dutchburn left 30/11/10 and is in reciept of pension and so the CETV is nil.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

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.....Chief Executive.....Date